

10th edition

Social Security, Medicare & Government Pensions

By Joseph L. Matthews
with Dorothy Matthews Berman



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INTRODUCTION

How to Use This Book

Are you approaching retirement, or are you disabled? Do you help support someone who is?

If so, you may be facing a series of problems for which you are unprepared: getting the most retirement and pension income and obtaining the broadest medical coverage you can afford. People in their retirement years may have access to a wide variety of programs to help with financial support and medical care. But many people are unaware of the extent of such programs, or are unable to wade through the programs' rules and regulations, and so do not receive all the benefits they could.

For people who are or soon will be on fixed incomes, the unnecessary loss of benefits and protection can cause critical problems. This book is intended to help you get all the benefits to which you are entitled: Social Security (both retirement and disability based), Supplemental Security Income, veterans benefits, and civil service benefits.

Most people are particularly concerned with getting the broadest possible medical coverage they can afford—knowing well that a serious medical problem can cost a fortune. Almost everyone is aware that Medicare is available, but few people understand how it works and what it does and does not cover. This book carefully, completely, and in plain language explains Medicare rules and regulations. It also explains how the holes in Medicare can be filled by medigap private insurance, managed care health plans, Medicaid, and veterans benefits.

Locating Chapters That Fit Your Needs

Each chapter in this book explains a different benefit program or set of laws designed to protect the rights of older Americans. It explains how each particular program works, and how it may relate to the other programs discussed in the book. Not all of these benefits will apply to

you. However, even if you don't think you are eligible for a particular benefit, take a look at the general requirements discussed in that chapter. You may be surprised to find that a program, or some part of it, applies to you in ways you had not previously realized. Pay special attention to explanations of how your income, or your participation in one benefit program, might affect your rights in another program.



You have earned these benefits. A key word in this book is “entitled.” Almost all of the benefits discussed here are paid to you because you worked for them, paying contributions into the system throughout your working life. If you are an older American facing retirement and a fixed income, you need all the financial support these programs are supposed to provide. And you are entitled to it.

Depending on your age and stage of life, there are a number of major issues you should consider as you first scan through the book.



Private pensions and 401(k) deferred benefit plans are far more complex than can be covered in a book of this breadth. We recommend that you consult *IRAs, 401(k)s & Other Retirement Plans: Taking Your Money Out*, by Twila Slesnick and John C. Suttle (Nolo).

If You Are Age 55 or Older and Not Yet Retired

- Find out how soon (at what age) you will become eligible for Social Security retirement benefits. (See Chapter 2, Section B.)
- Learn how much your Social Security retirement benefits will be reduced if you retire early or increased if you retire later. (See Chapter 2, Sections B and C.)
- Find out how much income you can earn without affecting your Social Security benefits. (See Chapter 2, Section D.)
- See whether you can claim civil service retirement benefits if you have ever worked for the federal, state, or local government or any public agency or institution—school system, library, public health facility. (See Chapter 9, Sections A and B.)
- Check the rules of your private pension plan—if you worked for any private company that had a pension plan, or if you belonged to any union—including whether your pension will be affected by your Social Security benefits. (Private pension plans are outside the scope of this book.)

If You Are Within Six Months of Your 65th Birthday

- Obtain a current estimate of what you'll receive in retirement and dependents benefits from Social Security, your civil service retirement system, and the private pension plan of any company where you've worked for at least three years, and from the Department of Veterans Affairs if you are a veteran. (See Chapter 1, Sections A and G; and Chapters 9 and 10.)

- Be ready to claim your Medicare coverage as soon as you become eligible. (See Chapter 11, Sections B, C, and D.)
- Look into ways to supplement your Medicare coverage, including medigap health plans to supplement Medicare, or HMOs, or managed care plans. (See Chapters 13 and 14.)
- If you have low income and few assets, check into your eligibility for assistance with medical bills from Medicaid. (See Chapter 15.)

If You Are 65 or Older and Retired

- If you have a low income and few assets, see whether you can get financial assistance from the Supplemental Security Income (SSI) program. (See Chapter 6, Section A.)
- Arrange for your access to medical treatment, after reading about the Medicare rules as well as those of your Medicare managed care or medigap insurance plan. (See Chapters 12, 13, 14, and 15.)
- If you have low income and few assets, see whether you are eligible for Medicaid or other state programs that help pay medical bills. (See Chapter 15, Section B.)
- If you were in the military, see whether you can claim financial or medical benefits from the Department of Veterans Affairs (VA).

If You Can Work Very Little or Not at All Because of a Physical or Mental Condition

- Look into whether you might qualify for Social Security disability benefits. (See Chapter 3, Sections A and B.)

- If you have low income and few assets, see whether you might qualify for Supplemental Security Income (SSI). (See Chapter 6, Section A.)
- If you were in the armed forces and your physical condition is in any way related to your time in the service, investigate the qualification rules for veterans disability benefits and medical care. (See Chapter 10, Sections B and E.)

If You Are a Surviving Spouse or Former Spouse of a Worker Who Is Retirement Age

- Learn whether you're eligible for Social Security or civil service survivors and dependents benefits. (See Chapters 4 and 5.)
- Obtain an estimate of your own retirement benefits, and compare them to estimates of survivors or dependents benefits. (See Chapter 1, Sections F and G.)
- Check the rules of the pension plan of any company or government entity for which your spouse worked for more than three years. (See Chapter 9 for government pensions.)
- If you or your spouse were in the military, see if there are any veterans benefits to which you might be entitled. (See Chapter 10.)

If You Are Age 60 or Older and Are Considering Getting Married

- Find out what effect marriage would have on your right and your intended spouse's right to collect Social Security retirement, survi-

vors, and dependents or disability benefits, and on the amount of those benefits. (See Chapter 2, Section C; Chapter 4, Sections A and E; Chapter 5, Section A.)

- Determine what effect marriage would have on your and your intended's eligibility for Supplemental Security Income (SSI) and Medicaid. (See Chapter 6, Section A; Chapter 15, Section B.)

Living Together: Unofficial Marriages and Benefit Programs

As you go over the rules of the specific programs, you will notice that eligibility for and amounts of many benefits to which you may be entitled often depend on your marital status. While Social Security and other programs provide a number of benefits to the spouse of a worker, they do not provide for people who live together without being married.

On the other hand, eligibility for some benefits and the amounts to which you may be entitled depend on the combined amount of income and assets of a claimant and his or her spouse. If you are not married, your partner's income and assets are not generally counted in determining your financial position, and so you are more likely to be eligible for benefits.

Many people live together in the belief they have a common law marriage—a legally recognized marriage—even though they never went through a formal ceremony, took out a marriage license, or filed a marriage certificate.

In fact, common law marriages are recognized only in Alabama, Colorado, District of Columbia, Iowa, Kansas, Montana, Oklahoma, Pennsylvania, Rhode Island, and South Carolina. In Georgia, Idaho, Ohio, and Pennsylvania, common law marriages are recognized only if they were formed before a certain date. If you do not live in one of these states and meet your state's particular requirements, you do not have

a common law marriage, no matter how long you have lived with another person or shared the same name, life, and family.

If you do live in one of these states, you will only be considered to have a common law marriage if you and a person of the opposite sex intend to be considered as married. You can show this in a number of ways—including living together as husband and wife for several years, using the same last name, referring to yourselves as married, having children together and giving them the family name you share, and owning property together.

Anything that shows that you consider yourselves married can be considered as evidence that you have a common law marriage. You can even write out an agreement that says you regard yourselves as being in a common law marriage. However, there is no one thing you can count on to absolutely prove the existence of your common law marriage. And nothing guarantees that Social Security or other programs will consider you married when making a decision about your benefits.

Finally, no matter how much evidence you have that you have a common law marriage, if either you or the person with whom you live is still lawfully married to someone else, there can be no common law marriage.

Icons Used in This Book

To aid you in using this book, the following icons are used:



The caution icon warns you of potential problems.



This icon indicates that the information is a useful tip.



This icon refers you to helpful books or other resources.



This icon indicates when you should consider consulting an attorney or other expert.



This icon refers you to a further discussion of the topic somewhere else in this book.



This icon helps you supplement the information in this book with resources available on the Internet.

Getting Help From the Internet

The Internet has greatly increased public access to information about government programs—at least for people who have access to a computer. However, not all of this information was created equal. The websites, both government and private, range from the very helpful—with detailed information and interactive forms—to the utterly useless or commercial.

This book will point you to the most useful websites covering government retirement, pension, and medical benefit programs. You can also search for information on your own, using search engines such as www.google.com—but before you believe information given on any one website, confirm it elsewhere.





Social Security: The Basics

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Social Security is the general term that describes a number of related programs—retirement, disability, dependents, and survivors benefits. These programs operate together to provide workers and their families with some monthly income when their normal flow of income shrinks because of the retirement, disability, or death of the person who earned that income.

The Social Security system was initially intended to provide financial security for older Americans. It was meant to help compensate for limited job opportunities available to older people in our society. And it was intended to help bridge the financial gaps created by the disappearance of the multigenerational family household—a break-up caused in large measure by the need for American workers to move around the country to find decent employment.

Unfortunately, this goal of providing financial security is today increasingly remote. The combination of rapidly rising living costs, stagnation of benefit amounts, and penalties for older people who continue to work has made the amount of support offered by Social Security less adequate with each passing year. This shrinking of the Social Security safety net makes it that much more important that you get the maximum benefits to which you are entitled.

This chapter explains how Social Security programs operate in general. It is helpful to know how the whole system works before determining whether you qualify for a particular benefit program and how much your benefits will be. Once you understand the basic premises of Social Security, you will be better equipped to get the fullest benefits possible from all Social

Security programs for which you might qualify. (See Chapters 2, 3, and 5.)

A. History of Social Security

Public images of our society generally render invisible many millions of economically hard-pressed older Americans. The older person with little income and assets is left out of the standard media pictures of two-car, two-kid suburbanites and of wealthy retired couples in gated luxury communities. Modern Western capitalism produces expendable workers. And the most vulnerable, such as people older than 65, are the most easily expended.

In the most advanced of modern industrial nations, the United States, the position of expendable workers is the worst. The richest 1% of U.S. households controls about 40% of the nation's wealth, and the poorest 20% of the population earns only about 5% of total after-tax income. These figures for the distribution of wealth are twice as large as those of Great Britain, a society commonly thought to have a wide divide separating rich and poor.

During periods of extreme economic retrenching, the number of people cast off by the economy spills over the normal barriers of invisibility. And with so many people during these crises sharing their complaints about economic injustice, it is sometimes difficult to keep them all under control. One such period of extreme economic dislocation was the Depression of the 1930s. Many millions of people were displaced—not only from job, home, and family, but from any hope for a place in the economy.

I. The Beginning of Social Security

Faced with this crisis and with the possibility of massive social upheaval, Franklin Roosevelt and Congress decided to act. Roosevelt pushed through a number of programs of national financial assistance—one of which was a system of retirement benefits called Social Security, enacted into law in 1935.

When benefits began, Social Security retirement cushioned slightly the crushing effects of the Depression. But retirement benefits were set at levels that were never enough to guarantee a standard of living above the poverty line. In 1939, Social Security benefits were extended to a retired worker's spouse and minor children; in 1956, to severely disabled workers. These extensions helped cover more people in need, but neither new program deviated from the basic premise of Social Security: provide just enough to keep starvation from the door, but not enough to guarantee a decent standard of living.

2. Current Threats to the System

The United States is presently in the throes of yet another economic upheaval, one that rivals the Depression. Millions of older people find it increasingly difficult to get by on their meager pensions, their low-paying part-time jobs, and their Social Security benefits.

More than 30 million people receive Social Security retirement benefits, which average a little over \$900 per month. Another five million widows and widowers receive survivors benefits, averaging about \$880 per month. Over six mil-

lion disabled workers receive Social Security disability benefits, on average about \$875 per month. And some five million spouses and children of retired or disabled workers receive dependents benefits, which average around \$450 per month per person. Although these add up to a hefty federal outlay, the average figures show how thinly the benefits are being spread. Recipients' monthly checks are usually not enough to maintain a decent standard of living. And there are plenty of people receiving less than the average amount, whose financial situation may be truly dire.

Despite these low averages, the system is coming under pressure to pay out even lower amounts. This pressure is being set off by a steady increase in the number of retirees who collect Social Security benefits. The total benefits they collect is catching up with the total taxes that younger workers pay into the system. If this system of taxing and benefits remains the same, in 15 or 20 years the scales will have completely tipped, and there won't be enough young workers to support the demand for Social Security benefits. There is a backup source of cash—the Social Security Trust Fund—but if this gets tapped into as the sole cash source, it, too will run dry, in about 35 to 40 years.

Clearly, the system requires some adjustment. But this need is providing camouflage for certain interests—particularly on Wall Street—to get their hands on the vast Social Security investment funds and divert them into the stock market. A more sensible approach might be to apply the Social Security tax to high-income earnings. However, national politicians and their wealthy supporters are less than interested in this. Another approach might be to reduce benefits to persons over retirement age who continue to earn a high income from work or in-

vestments. Yet another option would be to slightly raise the age at which full benefits are available. In combination, just a few of these changes could stabilize Social Security far into the future and keep the Wall Street folks from skimming a share off the top.

3. What You Can Do

In response to this deteriorating situation, anyone facing retirement should take two important steps.

First, understand the rules regarding Social Security benefits. (These are described in Chapters 1 through 5.) That will enable you to plan wisely for your retirement years, including answering the basic questions of when to claim your benefits and how much you can work after claiming them.

And second, become aware and active concerning proposed moves by Congress regarding the Social Security and Medicare programs. Local senior centers and national seniors organizations such as the Alliance for Retired Americans in Washington, DC (202-974-8222, www.retiredamericans.org) are good sources of current information.

If you are even beginning to think about your retirement, it is not too early to begin trying to safeguard it.

B. Social Security Defined

Social Security is a series of connected programs, each with its own set of rules and payment schedules. All of the programs have one

thing in common: Benefits are paid—to a retired or disabled worker, or to the worker's dependent or surviving family—based on the worker's average wages, salary, or self-employment income in work covered by Social Security.

The amount of benefits to which you are entitled under any Social Security program is not related to your need. Instead, it is based on the income you have earned through years of working. In most jobs, both you and your employer will have paid Social Security taxes on the amounts you earned. Since 1951, Social Security taxes have also been paid on reported self-employment income.

Social Security keeps a record of your earnings over your working lifetime and pays benefits based upon the average amount you earned. However, the only income considered is that on which Social Security tax was paid. Income such as interest, dividends, sale of a business or investments, and unreported income is not counted in calculating Social Security benefits.

Four basic categories of Social Security benefits are paid based upon this record of your earnings: retirement, disability, dependents, and survivors benefits.

I. Retirement Benefits

You may choose to begin receiving Social Security retirement benefits as early as age 62. But the amount of your benefits permanently increases for each year you wait, until age 70. The amount of your retirement benefits will be between 20% of your average income (if your income is high) and 50% (if your income is low). For a 65-year-old single person first claiming

retirement benefits in 2005, the average monthly benefit is about \$950; \$1,575 for a couple. The highest earners claiming their benefits in 2005 would receive about \$1,940 per month; \$2,450 for a couple. These benefits increase yearly with the cost of living. (See Chapter 2 for a full description of retirement benefits.)

2. Disability Benefits

If you are younger than 65 but have met the work requirements and are considered disabled under the Social Security program's medical guidelines, you can receive disability benefits. The amount of these benefits will be roughly equal to what your retirement benefits would be. (See Chapter 3 for a full discussion of disability benefits.)

3. Dependents Benefits

If you are married to a retired or disabled worker who qualifies for Social Security retirement or disability benefits, you and your minor or disabled children may be entitled to benefits based on your spouse's earning record. This is true whether or not you actually depend on your spouse for your support.

Married recipients should determine whether they will receive a greater sum from the combination of one Social Security benefit and one dependent benefit or from two Social Security retirement benefits, (assuming both partners are entitled to one). They may be awarded retirement or dependent benefits, but not both. (See Chapter 4 for a full discussion of dependents benefits.)

4. Survivors Benefits

If you are the surviving spouse of a worker who qualified for Social Security retirement or disability benefits, you and your minor or disabled children may be entitled to benefits based on your deceased spouse's earnings record. (See Chapter 5 for a full discussion of survivors benefits.)



You can choose which program to claim benefits from. You may meet the eligibility rules for more than one type of Social Security benefit. For example, you might be technically eligible for both retirement and disability, or you might be entitled to benefits based on your own retirement as well as on that of your retired spouse. You can collect whichever one of these benefits is higher, but not both.

C. Eligibility for Benefits

The specific requirements vary for qualifying to receive retirement, disability, dependents, and survivors benefits. The requirements also vary depending on the age of the person filing the claim and, if you are claiming as a dependent or survivor, on the age of the worker.

However, there is a general requirement that everyone must meet to receive one of these Social Security benefits. The worker on whose earnings record the benefit is to be paid must have worked in "covered employment" for a sufficient number of years by the time he or she claims retirement benefits, becomes disabled, or dies.

I. Earning Work Credits

All work on which Social Security taxes are reported is considered covered employment. About 95% of all American workers—about 160 million people—work in covered employment. For each year you work in covered employment, you receive up to four Social Security work credits, depending on the amount of money you have earned. Once you have accumulated enough work credits over your lifetime, you, your spouse, and your minor or disabled children can qualify for Social Security benefits.

The amounts of work credits you need in order to qualify for specific programs is discussed in Chapter 2 (retirement benefits), Chapter 3 (disability benefits), Chapter 4 (dependents benefits), and Chapter 5 (survivors benefits).

The Social Security Administration keeps track of your work record through the Social Security taxes paid by your employer and by you through FICA taxes.

The self-employed—that is, people who take a draw from a self-owned or partnership business, or who receive pay from others without taxes being withheld—earn Social Security credits by reporting income and paying tax for the net profit from that income on IRS Schedule SE. Income that is not reported will not be recorded on your earnings record. Although many people fail to report income to avoid paying taxes, a long-term consequence is that the unreported income will not count toward qualifying for Social Security retirement or other benefits, and will reduce the amount of benefits for those who do qualify.

The Importance of Names and Numbers

The Social Security system does everything—records your earnings, credits your taxes, determines and pays your benefits—according to your Social Security number. On every form you fill out or correspondence you have with the Social Security Administration, you must include your Social Security number. You should also use your name exactly as it appears on your Social Security card. This will make it easier for Social Security to track the correct records.

If you have used more than one name on work documents, indicate all names you have used on correspondence with the Social Security Administration. As long as you have used the same Social Security number, your records should reflect all of your earnings.

If you have changed your name and want to ensure that all your future earnings will be properly credited to your Social Security record, you can protect yourself by filling out an Application for Social Security Card. This form allows you to register your new name and match it with your existing Social Security number. You will be sent a new Social Security card with your new name, but the same number.

To complete this form, you must bring to your local Social Security office the originals or certified copies of documents which reflect both your old and new names. If your name has changed because you married or remarried, bring your marriage certificate.

If your name change is due to divorce, bring the final order of divorce, which includes reference to the return of your former name.

If you have any questions, particularly concerning the type of documents you may bring to show your old and new names, call Social Security at 800-772-1213.

2. Coverage for Specific Workers

There are special Social Security rules for coverage of some workers in certain sorts of employment.

a. Self-Employed Before 1951

Self-employment earnings have been covered by Social Security only since 1951. Self-employment earnings before then had no Social Security tax obligations and so were not applied to a worker's earnings record.

If you had self-employment earnings before 1951, they will not help you qualify for any type of Social Security benefits. Certain types of military service may make you eligible, as described in Subsection e, below. And if you do qualify for benefits, the amounts you earned in self-employment before 1951 will not be counted in figuring how much those benefits will be.

b. Federal Government Workers

If you were hired as an employee of the federal government on or after January 1, 1984, all your work for the government since then has been covered by Social Security just as if you had worked for a private employer.

If you worked for the federal government before 1984, your work both before and after January 1, 1984 has been covered by the separate federal Civil Service Retirement System. (See Chapter 9 for a full description of federal retirement benefits.)

c. State and Local Government Workers

Many state and local government workers are not covered by Social Security. State government employees are usually covered by their own pension or retirement systems, and local government employees have their own public agency retirement system, or PARS.

However, some state and local government employees are covered by Social Security instead of—or in addition to—a state or PARS pension system. This is because some state and local governments chose Social Security coverage for their workers instead of depending entirely on a system of their own. If so, they and their workers pay at least some Social Security taxes. And workers under these plans are entitled to Social Security benefits if they meet the other regular requirements.

State and local government workers who are not covered by their pension or retirement plans—mostly part-time, temporary, or probationary workers, or workers who were too old to qualify for the retirement plans when they began employment—are covered by Social Security for their government work.

If you are a government employee and aren't sure whether you are covered by Social Security, check with the personnel office at your workplace. And remember, even if your employment at a state or local agency does not entitle you to Social Security benefits, any other work you have done during your lifetime may qualify you, if you paid Social Security taxes.

d. Workers for Nonprofit Organizations

Since 1984, all employment for charitable, educational, religious, or other nonprofit organiza-

tions is covered by Social Security. Before that time, however, nonprofit organizations were permitted to remain outside the Social Security system, and many chose to do so. Because people who worked for such organizations were left out of any retirement plan, the Social Security system now permits some of them to qualify for benefits with about half of the normal number of years of work credit.

If you reached age 55 before January 1, 1984, and you worked for such a nonprofit organization, you and your family can qualify for Social Security benefits with a reduced number of work credits. The exact amount you need for each benefit is discussed in the chapter that covers that specific benefit: retirement (see Chapter 2), disability (see Chapter 3), dependents (see Chapter 4), and survivors (see Chapter 5).

Employees of Churches or Religious Organizations

Certain church organizations and religious groups do not contribute to the Social Security system for the people who work for them. As a result, the people who work for them must pay not only their own share of Social Security taxes, but also the share normally paid by an employer. That amounts to a 15.3% Social Security tax on an individual's wages, in addition to income taxes.

Employees of these nonpaying churches or religious organizations must file a self-employment tax form (Form 1040, Schedule SE) and pay this full Social Security tax with their federal tax return. By paying the tax, the employee's work is credited to his or her Social Security earnings record.

e. Members of the Military

Whether your military service was considered by Social Security to be "covered employment" depends on when you served and whether you were on active or inactive duty. From 1957 on, all service personnel on active duty have paid Social Security taxes, and so all active service from that date is covered employment. Since 1988, periods of active service, such as reserve training, while on inactive duty have also been covered.

If you served in the armed forces between 1940 and 1956, you may also have accumulated some Social Security work credits if you met certain additional conditions. (See "Special Rules for Military Service 1940 to 1956," below.)

f. Household Workers

Household work—cleaning, cooking, gardening, child care, minor home repair work—has been covered by Social Security since 1951; work before that date is not credited on a worker's earnings record.

A major problem for household workers is that most employers do not report their employees' earnings to the Internal Revenue Service (IRS) and do not pay Social Security taxes on those earnings. Of course, a lot of domestic workers do not want their earnings reported. They are paid so little that they prefer to receive the full amount, often in cash, without any taxes withheld.

One result of this nonreporting, however, is that the earnings do not get credited to the worker's Social Security record. So when the worker or worker's family later seeks Social Security benefits, they may have trouble qualify-

ing and, if qualified, will have lower benefit amounts.

If you want your earnings from household work reported to Social Security, you have several options. If you work for a number of different employers and make less than \$1,000 per year from any one of them, you can report that income yourself as self-employment income and pay 15.3% self-employment tax on it in addition to the regular income tax. Paying self-employment tax, on federal income tax Form 1040, Schedule SE, credits the earnings to your Social Security earnings record.

If you work for any one employer who pays you a total of \$1,000 or more over the course of a year, you can ask that employer to withhold Social Security taxes from your pay, report your income to Social Security, and pay the employer's share of the Social Security tax on that income, as the law requires. (See "Employer's Duty to Report Earnings of Household Workers," below.) If the employer refuses, you are faced with a difficult choice. You can report the refusal to your local Social Security office. This will permit you to begin the process of gaining Social Security credit for your earnings. It will also mean that you will have 6.75% of your pay deducted for your portion of Social Security taxes. And, of course, it is likely to strain relations with your employer.

If you did household work between 1951 and 1993, employers were required by law to report your income and pay Social Security taxes on it if you earned more than \$50 per quarter-year. Very few employers did so, however. If you want to get Social Security earnings credit for any of those years, you may be able to do so by providing the Social Security Administration with some proof of your income. Before

you report this income, request a copy of your earnings record from Social Security, which will tell you what work has already been credited to your record. (See Section F.) Then, if you have any kind of written proof of unreported income—copies of pay stubs, checks, bank deposits, income tax returns—you may show it to your local Social Security office and have that income credited to your earnings record. Be aware, however, that if Social Security credits you with these previously unreported amounts of income, you may have to pay your share—6.75%—of the previously unpaid Social Security tax.

Employer's Duty to Report Earnings of Household Workers

If an employer hires a household worker—cleaner, cook, gardener, child sitter, home care aide—who is not employed by and paid through an agency, and the employer pays that worker a total of \$1,000 or more during the year, the employer is required by law to report those payments and pay Social Security taxes on them. This rule exempts any worker who was under age 18 during any part of the year.

An individual employer can report these taxes on his or her own federal income tax return Form 1040, and pay the Social Security tax obligation along with the personal income taxes. To file and pay these taxes, the employer will need the name of the employee as it appears on his or her Social Security card, the employee's Social Security number, and the amount of wages paid.

g. Farmworkers

Since 1954, farm and ranch work has been included in the Social Security system. If you do crop or animal farmwork, your employer must report your earnings, and pay Social Security taxes on them. The employer must also withhold your share of Social Security taxes from your paycheck if you earn \$150 or more from that employer in one year, or if the employer pays \$2,500 or more to all farm laborers, regardless of how much you earn individually. Any amounts you are paid in housing or food do not have to be reported by the employer.

Farmworkers have long faced problems with employers who do not pay their share of the Social Security tax. An employee gets Social Security credit for earnings only if the earnings are reported to the Social Security Administration and Social Security tax is paid. If your employer fails to pay its share of tax, and fails to withhold your share of Social Security taxes from your paycheck, the burden of Social Security taxes falls unfairly on you. Either no Social Security taxes are paid at all, in which case you do not get earnings credits that will eventually lead to retirement or other benefits; or you pay Social Security taxes as a self-employed person, which is at twice the tax rate you should be paying.

To make sure your farmwork is counted toward your Social Security record, check your pay stub to see if Social Security taxes—labeled FICA—are being withheld. Also ask the person who handles payroll for paperwork indicating that Social Security taxes are being paid on your earnings. If your employer is not paying Social Security taxes on your earnings, or you get the

runaround and you are unsure what the employer is doing, ask your local Social Security office to find out for you.

If you are worried about your employer finding out that you are checking on this, ask the Social Security worker to make a confidential inquiry. Social Security can request all the employer's wage records without letting the employer know which employee in particular has brought the matter to its attention.

D. Earning Work Credits

To receive any kind of Social Security benefit—retirement, disability, dependents, or survivors—the person on whose work record the benefit is to be calculated must have accumulated enough work credits. The number of work credits you need to reach the qualifying mark—what Social Security calls insured status—varies depending on the particular benefit you are claiming and the age at which you claim it.

You can earn up to four work credits each year, but no more than four, regardless of how much you earn. Before 1978, work credits were measured in quarter-year periods: January through March, April through June, July through September, and October through December. You had to earn a specific minimum amount of income to gain a work credit for that quarter.

- Between 1936 and 1978, you received one credit for each quarter in which you were paid \$50 or more in wages in covered employment.

- Between 1951 and 1978, you received one credit for each quarter in which you earned and reported \$100 or more from self-employment.
- Beginning in 1978, the rules were changed to make it easier to earn credits. From 1978 on, you receive one credit, up to four credits per year, if you earn at least a certain amount in covered employment, regardless of the quarter in which you earn it. That means that if you earn all your money during one part of the year and nothing during other parts of the year, you can still accumulate the full four credits. The amount needed to earn one credit increases yearly. In 1978, when the new system was started, it was \$250; in 2005, it increased to \$920.

Example: In 1950, Ulis was paid \$580 between January and March, nothing between April and July when he could not work because of a back injury, \$340 in August, and \$600 in cash from self-employment in October and November. For the year 1950, Ulis earned two credits: one credit for the first quarter, in which he was paid more than the \$50 minimum; nothing in the second quarter, so he got no credit; one credit in the third quarter, because he earned well over the \$50 minimum even though he worked only one month; and nothing for the last quarter, because in 1950 self-employment income was not covered by Social Security.

Example: Eve was paid \$800 in January 1978, but did not earn anything the rest of the year. Based on the earnings test in effect in 1978, she got three credits for the year—one for each \$250 in earnings—based on her earnings for January alone.

Example: Rebecca was paid \$500 a month in 2005 at her part-time job, for total earnings for the year of \$6,000. Since her earnings of \$6,000 divided by \$900 (the amount needed to earn one credit in 2005) is more than 4, she received the maximum four credits for 2005.

Special Rule for Military Service 1940 to 1956

Before 1957, Social Security taxes were not paid by members of the military. However, Congress passed a rule that permits members of the military during those years to earn work credits for active duty service.

If you are receiving a military retirement pension for active duty, however, you cannot also receive Social Security credit for the same period. Your Social Security record can be credited with \$160 per month in earnings for active military service between September 16, 1940 and December 31, 1956 if:

- you served 90 or more days active service and were honorably discharged
- you were discharged because of a disability or injury which occurred in the line of duty, or
- you are applying for Social Security survivors benefits based on the record of a veteran who died on active service.

E. Determining Your Benefit Amount

If you are eligible for a Social Security benefit, the amount of that benefit is determined by a formula based on the average of your yearly reported earnings in covered employment since you began working. Wages before 1937 are not counted, however. And self-employment income before 1951 is not counted, either.

I. How Your Earnings Average Is Computed

Social Security computes the average of earnings differently depending on your age. If you reached age 62 or became disabled on or before December 31, 1978, the computation is simple: Social Security averages the actual dollar value of your total past earnings.

If you turned 62 or became disabled on or after January 1, 1979, Social Security divides your earnings into two categories: Earnings from before 1951 are credited with their actual dollar amount, up to a maximum of \$3,000 per year. From 1951 on, yearly limits are placed on earnings credits as shown in the chart at right, no matter how much you actually earned in those years.



Only employment-related income counts, and you must have paid Social Security taxes on that income. Other income that you may have earned, such as interest, dividends, capital gains, rents, and royalties, will not be considered in calculating your Social Security benefits.

Yearly Dollar Limit on Earnings Credits

1951 - 1954	3,600
1955 - 1958	4,200
1959 - 1965	4,800
1966 - 1967	6,600
1968 - 1971	7,800
1972	9,000
1973	10,800
1974	13,200
1975	14,100
1976	15,300
1977	16,500
1978	17,700
1979	22,900
1980	25,900
1981	29,700
1982	32,400
1983	35,700
1984	37,800
1985	39,600
1986	42,000
1987	43,800
1988	45,000
1989	48,000
1990	50,400
1991	53,400
1992	55,500
1993	57,600
1994	60,600
1995	61,200
1996	62,700
1997	65,400
1998	68,400
1999	72,600
2000	76,200
2001	80,400
2002	84,900
2003	87,000
2004	87,900
2005	90,000

2. Benefit Formula

Based on a worker's earnings record, the Social Security Administration computes what is called the worker's Primary Insurance Amount, or PIA. This is the amount a worker will receive if he or she claims retirement benefits at full retirement age, which is 65 for everyone born in 1937 or earlier. The full retirement age is 67 for those born in 1960 or later. (If you were born between 1938 and 1960, see "Retirement Age for Those Born After 1937" in Chapter 2.) The exact formula applied to each worker's earnings record depends on the year the worker was born.



There is no "minimum" Social Security benefit amount. If your average earnings were quite low, so will your check be.

Social Security benefits for a disabled worker (as described in Chapter 3), or for a worker's dependents (as described in Chapter 4), or survivors (as described in Chapter 5), are based on a percentage of the worker's PIA. You can get an estimate of your future retirement or disability benefits, or those of a worker on whose earnings record you will receive dependents or survivors benefits. (See Section F, below, for how to request this estimate.)

3. Taxes on Your Benefits

A certain amount of Social Security benefits may be taxable, depending on your total income. In determining whether you owe any income tax on your benefits, the Internal Revenue Service looks at what it calls your combined income. This consists of your adjusted gross income, as reported in your tax return, plus any nontaxable interest income, plus one-half of your Social Security benefits. If your combined income as an individual is between \$25,000 and \$34,000 (or, for a couple filing jointly, between \$32,000 and \$44,000), you may have to pay income taxes on 50% of your Social Security benefits. If your combined income is more than \$34,000 (\$44,000 for a couple filing jointly), you may owe income taxes on up to 85% of your benefits.

The way to calculate any income taxes you may owe on your Social Security benefits is explained in the instruction booklet that accompanies the Form 1040 federal tax return. The IRS also publishes a free information booklet explaining numerous tax rules pertaining to older people. It is called the *Older Americans' Tax Guide*, Publication 554. To get the booklet, call the IRS at 800-829-3676 or download it from their website at www.irs.gov.

Veterans May Receive Extra Earnings Credit

If you're a veteran of the U.S. armed forces, you may be eligible for extra earnings credit, including:

- an extra \$160 per month for active duty between September 16, 1940 and December 31, 1956, if you were honorably discharged after at least 90 days of service or released because of a line-of-duty injury, or if you apply for survivors benefits based on the work record of a veteran who died while on active duty
- an extra \$300 per quarter for active duty from 1957 through 1977
- \$100 of credit for each \$300 of active duty basic pay, up to a maximum credit of \$1,200 per year for active duty from 1978 through 2001. No extra credit is given if you enlisted after September 7, 1980 and did not complete at least 24 months' active duty or your full tour.

Notice that no extra credit is given for active duty after 2001.

Don't be alarmed if you don't see your extra credits for service from 1940 through 1967 reflected on your Social Security Statement. These will be added to your record when you actually apply for benefits, at which time you'll have to provide proof of your military service. Active duty earnings from 1968 on should be included in the benefit estimates on your Statement, although the extra credit amounts will not show up in the Statement's year-to-year list of your earnings.

F. Your Social Security Earnings Record

The Social Security Administration keeps a running computer account of your earnings record and the work credits it reflects. (It tracks these by use of your Social Security number.) Based on those figures, Social Security can give you an estimate of what your retirement benefits would be if you took them at age 62, 65, or 70. It can also estimate benefits for your dependents or survivors, or your disability benefits, should you need them.

It makes good sense to find out what your Social Security retirement benefits will be several years before you actually consider claiming them. You're probably curious, and finding out can help you plan for the future. And since so much is riding on your official earnings record, it is important to check the accuracy of that record every few years. You want to make sure that all your covered earnings are credited to you.

I. Checking Earnings Record and Estimated Benefits

To help you keep track of your earnings record and estimate of benefits, the Social Security Administration mails out copies of individual Social Security records on what is called a Social Security Statement.

A Social Security Statement is supposed to be mailed to everyone age 40 and older who is not currently receiving Social Security benefits.

If you have not received a Social Security Statement—or you received one more than a year ago and want a more recent estimate—you

may request one by filling out a simple form, SSA 7004, called a *Request for Social Security Statement*. This form is available in English and Spanish.

There are several ways to get the request form. It is available at the end of this chapter and at your local Social Security office, often in the front lobby, without waiting in line. It is available online, as described below. Or call Social Security at 800-772-1213 to request one by mail.

You may be sent an older version of this form, entitled *Request for Earnings and Benefit Estimate Statement*—that's okay: Social Security still accepts the older version.



The Internet gives you two options for figuring out your earnings record, via the Social Security Administration's Web page at www.ssa.gov/mystatement. The low-tech option is to download the *Request for Social Security Statement* form, fill it out by hand, and mail it in. To do this, click on "Need to Request a Statement?" then scroll down until you see the link for "Social Security Statement Request Form (SSA-7004)." Choose "SSA-7004 in pdf" for the most recent version.

The higher-tech option is to fill out the *Request* form online. After clicking "Need to Request a Statement?" scroll down to the gray bar saying "Request a Social Security Statement." You'll be led to an interactive form which asks for the same information as the printed form. After submitting your *Request* (whether by mail or online), expect the Social Security Statement to come to you by mail.

If you don't use the interactive Internet form, mail your completed *Request* form to:

Social Security Administration
Wilkes Barre Data Operations Center
P.O. Box 7004
Wilkes Barre, PA 18767-7004

2. Completing the Request Form

There are only a few questions you need to consider carefully when filling out the request form. Make sure you fill in your name exactly as it is on your Social Security card. That will help Social Security to track down any missing or misplaced records in case your earnings were ever mistakenly reported.

As to Part 6, which requests your earnings, do not worry about providing exact income figures. They are used only to provide you with an estimate of your benefits; your benefits will be based on your actual earnings as reported on your tax returns, not on the estimate you provide on this form. Even if you are off by a couple of thousand dollars on the income estimate you give here, it will have only a slight effect on your benefit estimate.

Part 7 asks you to indicate the age at which you plan to stop working. Again, this is just so that Social Security can estimate the number of years of earnings you still have before you can claim your retirement benefits. In no way does it commit you to anything. If you are not certain when you will stop working, put down age 65, which is currently considered full retirement age. If at any time you consider stopping work earlier or later than age 65, you can request another statement estimating your benefits.

Part 8 asks you to estimate your average yearly earnings between now and the time you think you will retire. Remember that this estimate only includes income from wages, salary, or self-employment, and does not include investment income, capital gains, gifts, or inheritance. If you are more than a few years away from claiming retirement benefits, this is a very difficult question to answer accurately. Unless you know that you are in line for a significant jump or decrease in earned income in the next few years, it is best to fill in your current income here.

Social Security will adjust the figure for inflation and will give you your benefit estimate in current dollars. If you are still a long way away from claiming retirement, the current income estimate and retirement figure Social Security provides will give you a more accurate picture of your benefits than if you try to speculate about what your salary might be years from now. You can judge what it would be like to live at today's cost of living on the amount Social Security estimates in today's dollars.

Once you have sent in your completed request form, it takes several weeks for the Social Security Administration to process it and mail you a copy of your earnings record.

G. Reading Your Social Security Statement

Your Social Security Statement consists of six pages (four if you are younger than age 55).



A sample Social Security Statement is available in other languages. While you can obtain your personal Statement only in English, comparing this to a sample in a language with which you're more comfortable may clarify the information. Sample Statements are currently available in Chinese, Italian, Korean, Polish, Tagalog, and Vietnamese. These can be obtained online at www.ssa.gov/mystatement, or by calling 800-772-1213.

Only pages two and three contain information that is personal to you. The other pages merely give a boilerplate overview of Social Security programs. See the sample pages two and three below, from the official sample provided by the SSA.

Note that the sample represents a person who is about 40 years old. If you are closer to retirement, the figures on your statement should look much different.



You may notice mistakes on your statement. There is a procedure for setting the record straight, covered in Section H, below. Failure to correct mistakes could result in a regular bite out of your monthly check.

Your Estimated Benefits

To qualify for benefits, you earn "credits" through your work—up to four each year. This year, for example, you earn one credit for each \$900 of wages or self-employment income. When you've earned \$3,600, you've earned your four credits for the year. Most people need 40 credits, earned over their working lifetime, to receive retirement benefits. For disability and survivors benefits, young people need fewer credits to be eligible.

We checked your records to see whether you have earned enough credits to qualify for benefits. If you haven't earned enough yet to qualify for any type of benefit, we can't give you a benefit estimate now. If you continue to work, we'll give you an estimate when you do qualify.

What we assumed—If you have enough work credits, we estimated your benefit amounts using your average earnings over your working lifetime. For 2004 and later (up to retirement age), we assumed you'll continue to work and make about the same as you did in 2002 or 2003. We also included credits we assumed you earned last year and this year.

We can't provide your actual benefit amount until you apply for benefits. **And that amount may differ from the estimates stated below because:**

- (1) Your earnings may increase or decrease in the future.
- (2) Your estimated benefits are based on current law.

The law governing benefit amounts may change.*
 (3) Your benefit amount may be affected by **military service, railroad employment or pensions earned through work on which you did not pay Social Security tax. Visit www.socialsecurity.gov/mystatement to see whether your Social Security benefit amount will be affected.**

Generally, estimates for older workers are more accurate than those for younger workers because they're based on a longer earnings history with fewer uncertainties such as earnings fluctuations and future law changes.

These estimates are in today's dollars. After you start receiving benefits, they will be adjusted for cost-of-living increases.

▼ *Retirement

You have earned enough credits to qualify for benefits. At your current earnings rate, if you stop working and start receiving benefits...

At age 62, your payment would be about...	\$882 a month
If you continue working until...	
your full retirement age (67 years), your payment would be about...	\$1,278 a month
age 70, your payment would be about...	\$1,594 a month

▼ *Disability

You have earned enough credits to qualify for benefits. If you became disabled right now,

Your payment would be about...	\$1,169 a month
--------------------------------	-----------------

▼ *Family

If you get retirement or disability benefits, your spouse and children also may qualify for benefits.

▼ *Survivors

You have earned enough credits for your family to receive survivors benefits. If you die this year, certain members of your family **may** qualify for the following benefits.

Your child...	\$911 a month
Your spouse who is caring for your child...	\$911 a month
Your spouse, if benefits start at full retirement age...	\$1,215 a month
Total family benefits cannot be more than...	\$2,233 a month

Your spouse or minor child may be eligible for a special one-time death benefit of \$255.

▼ Medicare

You have enough credits to qualify for Medicare at age 65. Even if you do not retire at age 65, be sure to contact Social Security three months before your 65th birthday to enroll in Medicare.

***Your estimated benefits are based on current law. Congress has made changes to the law in the past and can do so at any time. The law governing benefit amounts may change because, by 2042, the payroll taxes collected will be enough to pay only about 73 percent of scheduled benefits.**

We based your benefit estimates on these facts:

Your name...	Wanda Worker
Your date of birth...	May 5, 1963
Your estimated taxable earnings per year after 2003...	\$35,051
Your Social Security number (only the last four digits are shown to help prevent identity theft)...	XXX-XX-2004

Page two. The second page of your Statement shows dollar estimates of the benefits to which you'd be entitled under the various Social Security programs. As cautioned in the introductory paragraphs, these are only estimates. The precise figures will not become available until you actually claim your benefits. To arrive at these estimates, they've guessed at how much you'll earn per year until you reach retirement age—you can see their guess on the second-to-last line of this page. However, your earnings could rise or fall dramatically in the years ahead. Because of this uncertainty about the future, the less time that elapses between when you receive the estimates and when you actually claim your benefits, the more accurate the estimates are likely to be.

If you look at the sample, the first sentence next to "Retirement" reads "You have earned enough credits to qualify for benefits." This isn't mere boilerplate—this Statement would also tell you if you had *not* earned enough credits. If you hadn't, the Statement would also tell you how many more credits you needed to qualify.

The remainder of this Statement is largely self-explanatory, or will be after you've read other portions of this book. To figure out your "full retirement age," see Chapter 2, Section B2. For how your continuing to work after reaching full retirement age will increase your benefits, see Chapter 2, Sections B and D. The Social Security Disability program is explained in Chapter 3, family benefits in Chapter 4, survivors benefits in Chapter 5, and finally Medicare benefits in Chapters 11 through 14.

You'll note that no estimate is given for the family benefits that you'll receive—that's because these vary not only with the amount of your retirement benefits but also with the num-

ber of your minor children. Also, no figure is given for Medicare benefits—that's because the key issue is simply whether or not you've earned enough credits to qualify for coverage, which the Statement does tell you.

At the bottom of page two, make sure that your name appears exactly as it does on your Social Security card and that your birthdate and Social Security number are listed correctly.

Page three. The third page of your Statement actually breaks down your earnings history year by year, for your entire working life back to 1950. Any earnings before 1950 will be summarized on a single line. As explained in Section E, above, this history may not reflect every dollar you've earned—it includes only income on which you've paid Social Security taxes. Also, if you earned more than the maximum taxable earnings during a particular year, your earnings record will show only that maximum amount. (This is basically fair, since you wouldn't have paid any taxes into the system for amounts over these limits.)

You'll notice that the earnings record is broken into two columns, one titled "Your Taxed Social Security Earnings" and the other "Your Taxed Medicare Earnings." For most people, these two columns will contain the exact same numbers. However, some people will see higher numbers in the Medicare column. That's because since 1994 all earned income, even over and above the Social Security maximum, has been taxed for Medicare purposes. People who earned more than the maximum taxable income since 1994 will have paid more into the Medicare system than into the regular Social Security system.

Help Us Keep Your Earnings Record Accurate

You, your employer and Social Security share responsibility for the accuracy of your earnings record. Since you began working, we recorded your reported earnings under your name and Social Security number. We have updated your record each time your employer (or you, if you're self-employed) reported your earnings.

Remember, it's your earnings, not the amount of taxes you paid or the number of credits you've earned, that determine your benefit amount. When we figure that amount, we base it on your average earnings over your lifetime. If our records are wrong, you may not receive all the benefits to which you're entitled.

▼ **Review this chart carefully** using your own records to make sure our information is correct and that we've recorded each year you worked. You are the only person who can look at the earnings chart and know whether it is complete and correct.

Some or all of your earnings from **last year** may not be shown on your **Statement**. It could be that we still

were processing last year's earnings reports when your **Statement** was prepared. Your complete earnings for last year will be shown on next year's **Statement**. **Note:** If you worked for more than one employer during any year, or if you had both earnings and self-employment income, we combined your earnings for the year.

▼ **There's a limit on the amount of earnings on which you pay Social Security taxes each year.** The limit increases yearly. Earnings above the limit will not appear on your earnings chart as Social Security earnings. (For Medicare taxes, the maximum earnings amount began rising in 1991. Since 1994, **all** of your earnings are taxed for Medicare.)

▼ **Call us right away at 1-800-772-1213** (7 a.m.–7 p.m. your local time) if any earnings for years **before last year** are shown incorrectly. If possible, have your W-2 or tax return for those years available. (If you live outside the U.S., follow the directions at the bottom of page 4.)

Your Earnings Record at a Glance

Years You Worked	Your Taxed Social Security Earnings	Your Taxed Medicare Earnings
1979	474	474
1980	1,123	1,123
1981	1,983	1,983
1982	3,293	3,293
1983	4,461	4,461
1984	5,600	5,600
1985	6,950	6,950
1986	8,813	8,813
1987	10,941	10,941
1988	12,803	12,803
1989	14,520	14,520
1990	16,308	16,308
1991	17,920	17,920
1992	19,655	19,655
1993	20,534	20,534
1994	21,730	21,730
1995	23,155	23,155
1996	24,838	24,838
1997	26,806	26,806
1998	28,720	28,720
1999	30,824	30,824
2000	33,060	33,060
2001	34,237	34,237
2002	35,051	35,051
2003	Not yet recorded	

Did you know... Social Security is more than just a retirement program? It's here to help you when you need it most.

You and your family may be eligible for valuable benefits:

▼ When you die, your family may be eligible to receive survivors benefits.

▼ Social Security may help you if you become disabled—even at a young age.

▼ It is possible for a young person who has worked and paid Social Security taxes in as few as two years to become eligible for disability benefits.

Social Security credits you earn move with you from job to job throughout your career.

Total Social Security and Medicare taxes paid over your working career through the last year reported on the chart above:

Estimated taxes paid for Social Security:

You paid: \$24,723

Your employers paid: \$24,723

Estimated taxes paid for Medicare:

You paid: \$5,820

Your employers paid: \$5,820

Note: You currently pay 6.2 percent of your salary, up to \$87,900, in Social Security taxes and 1.45 percent in Medicare taxes on your entire salary. Your employer also pays 6.2 percent in Social Security taxes and 1.45 percent in Medicare taxes for you. If you are self-employed, you pay the combined employee and employer amount of 12.4 percent in Social Security taxes and 2.9 percent in Medicare taxes on your net earnings.



Regularly review your records. Your benefits estimate is based on the average of your earnings over your entire lifetime. Your earnings in the last few years before you claim retirement may be higher than most of your earlier working years, and if so will increase your average, and your benefits, significantly. For that reason, it is important to request an official statement every few years to keep track of your changing benefits estimate.

H. Correcting Your Record

Mistakes do occur in official earnings records. Social Security estimates that employers make mistakes in wage reports about 4% of the time. Social Security easily clears up most of these errors: misspelled names, transposed numbers. But one dollar of every \$100 reported to Social Security fails to be credited to the correct worker's record.

If you believe a mistake has been made on your record, you can do something about it even if it concerns wages from many years past.

I. Common Sources of Errors

The problem of unreported earnings occurs more frequently with people who have used more than one name—usually women who have changed their names when they married, or married and divorced, and who may have had

their earnings reported under both unmarried and married names.

The problem also appears to be more common for people whose family names the Social Security computer may have trouble identifying properly. Examples include:

- hyphenated names, such as Watson-Jones
- names with spaces between one part and another, such as de la France, and
- names in which the identifying family portion does not come at the end as in Anglo constructions, such as Park Chee Ho or Martina Rosales Rincon.

2. How to Spot Errors

To locate possible errors, start by checking the Social Security number on the earnings statement to make sure it is your earnings that are being calculated.

Next, check the amounts listed in columns two and three of page three with your own records of earnings. You may have records of your earnings in your income tax forms or pay stubs. Your place of work may also have pay records for a number of years. (See “Locating Your Earnings Records,” below.) Note that the amounts of your reported income listed in this column include only earned income from covered employment and do not include any income which is not wages, salary, or self-employment. This listed amount also does not include any self-employment income before 1951. Nor does it include any income over the amount listed for any one year in “Yearly Dollar Limit on Earnings Credits” in Section E, above. Even if you made more than that figure during the year, you got credit only for the maximum earnings amount listed.

Locating Your Earnings Records

If you find what you believe is an error caused by your current employer, ask the payroll person at your workplace to verify your Social Security earnings for the year in question and to give you a copy of paperwork showing those earnings.

If the earnings were for a previous employer, ask the personnel office there for records of your earnings. If it no longer has your records, or if the earnings were from self-employment, try to locate among your own records some written evidence of what you contend was your actual covered income for that year: tax returns, W-2 forms, pay stubs, bank deposit statements.

2. How to Request a Correction

When you have evidence of your covered earnings in the year or years for which you think Social Security has made an error, call Social Security's helpline at 800-772-1213, Monday through Friday from 7 a.m. to 12 p.m. Eastern time. (This is the line that takes all kinds of Social Security questions, and it is often swamped, so be patient. It is best to call early in the morning or late in the afternoon, late in the week, and late in the month.) Have all your documents handy when you speak with a representative.

If you would rather speak with someone in person, call your local Social Security office and make an appointment to see someone there, or drop into the office during regular business hours. If you drop in, be prepared to wait, perhaps as long as an hour or two, before you get to see a representative. Bring with you two copies of your benefits statement and whatever evidence supports your claim of higher income. That way, you can leave one copy with the Social Security worker. Write down the name of the person with whom you speak so that you can reach the same person when you follow up.

The process to correct errors is slow. It may take several months to have the changes made in your record. Even after Social Security says that it has corrected your record, be sure to request another benefits statement, just to double check.

One Year Correction Without Evidence of Income

Social Security Administration policy allows you to get credit for one year's earnings—in certain limited circumstances—even if you cannot come up with written evidence of those earnings. The rule applies only to earnings from 1978 on.

The rule applies if Social Security has a record of your earnings from an employer in a year immediately before or after the year you want corrected, and the earnings you are claiming for that year are consistent with the year just before or after it. In such cases, Social Security can give you credit for earnings in the amount you claim for that year even though neither you nor the employer has written evidence of those earnings.

I. U.S. Citizens' Rights to Receive Benefits While Living Abroad

If you are a U.S. citizen living in another country, you are theoretically entitled to the same Social Security benefits as if you lived in the United States. However, there are a few countries to which the Social Security Administration simply cannot send payments, regardless of any particular individual's right to benefits. These countries include Cuba, North Korea, Cambodia, Vietnam, or any country formerly part of the Soviet Union (except Russia, Armenia, Estonia, Latvia, and Lithuania, to which payment may be sent). Your money won't just disappear into a black hole, however. If you go to another country where Social Security can send payments, you can ask them to send you a check for all the benefits you're owed there.

J. Receiving Benefits as a Noncitizen

It is increasingly common for people who are not U.S. citizens to live and work here for long periods of time. This section explains your rights to collect Social Security benefits if you are not a U.S. citizen, whether you're living in the United States now or have since left to live in another country.

I. Noncitizens Living in the U.S.

Noncitizens living in the United States are entitled to all the Social Security benefits that they or their spouse or parents have earned—under

the same rules as U.S. citizens—if they are lawfully in the United States. For example, you might benefit from this if you:

- were not a U.S. citizen during some or all of the time you or your family member worked in the United States, but have since become a U.S. citizen, or
- are not a U.S. citizen, but are a lawful permanent U.S. resident or have another immigration status permitting you to be lawfully present in the United States.

2. Non-U.S. Citizens Living Abroad

Many non-U.S. citizens live and work for a time in the United States, paying Social Security taxes and earning enough work credits to qualify for benefits for themselves and their families. However, many of these people ultimately leave the United States. Their ability to collect earned Social Security benefits after departing depends in large part on whether the United States has entered into agreements with their home countries. If you've formerly worked in the United States, you need to look at three things to figure out your eligibility for benefits, including:

- your country of citizenship
- the country where you're living when you request Social Security benefits, and
- the type of benefit you're requesting.

What if you begin receiving benefits while you're in the United States, but later move abroad? If you don't qualify under one of the situations described below, your benefits will be cut off six months after you leave the United States.

a. Countries Whose Citizens Are Entitled to Collect U.S. Benefits

If you are a citizen of any of the following countries, you may receive any Social Security benefit to which you are entitled, regardless of what country you're actually living in:

Austria	Greece	Netherlands
Belgium	Ireland	Norway
Canada	Israel	Portugal
Chile	Italy	Spain
Finland	Japan	Sweden
France	South Korea	Switzerland
Germany	Luxembourg	United Kingdom

b. Countries Whose Residents Are Entitled to Benefits

You may also receive any benefit to which you are entitled if you are a legal resident—but not necessarily a citizen—of any of the following countries:

Australia	Germany	Norway
Austria	Greece	Portugal
Belgium	Ireland	Spain
Canada	Italy	Sweden
Chile	South Korea	Switzerland
Finland	Luxembourg	United Kingdom
France	Netherlands	

Also note that if you live in, but are not a citizen of, Austria, Belgium, Germany, Sweden, or Switzerland, you may receive dependents or survivors benefits (described in Chapters 4 and 5) only if the worker on whose Social Security record you would receive benefits is a citizen of the United States or of the country where you now live.

c. Eligibility Based on Type of Benefits to Be Received

If you are not a citizen of the United States or of any of the countries listed in Subsection a, above, you may still be entitled to receive retirement, dependents, or survivors benefits.

Your eligibility for retirement benefits based on your own work record (as described in Chapter 2) depends on whether you are a citizen of any one of more than 100 other countries. To find out whether your country of citizenship is currently on the lists (these lists change from time to time), and the particular rules that might apply to you, call Social Security at 800-772-1213. Request a copy of pamphlet #05-10137, *Your Payments While You Are Outside the United States*. You can also view the pamphlet online at www.ssa.gov/international.

Your eligibility for dependents or survivors benefits (described in Chapters 4 and 5) depends on any one of the following being true:

- You lived in the United States for at least five years, during which time you had the family relationship with the worker on whose record you would claim dependents or survivors benefits.
- If you are claiming benefits based on your parents' work record, your parents lived in the United States for at least five years while they were married.
- You were initially eligible for benefits before January 1, 1985.
- You are entitled to benefits based on the record of a worker who died while in U.S. military service or as a result of a service-connected injury or illness.

Request for Social Security Statement

☐ Please check this box if you want to get your *Statement* in Spanish instead of English.

Please print or type your answers. When you have completed the form, fold it and mail it to us. (If you prefer to send your request using the Internet, contact us at www.socialsecurity.gov)

1. Name shown on your Social Security card:

First Name _____ Middle Initial _____

Last Name Only _____

2. Your Social Security number as shown on your card:

- -

3. Your date of birth (Mo.-Day-Yr.):

- -

4. Other Social Security numbers you have used:

- -

- -

5. Your Sex: ☐ Male ☐ Female

For items 6 and 8 show only earnings covered by Social Security. Do NOT include wages from state, local or federal government employment that are NOT covered for Social Security or that are covered ONLY by Medicare.

6. Show your actual earnings (wages and/or net self-employment income) for last year and your estimated earnings for this year.

A. Last year's actual earnings: (Dollars Only)

\$, .

B. This year's estimated earnings: (Dollars Only)

\$, .

7. Show the age at which you plan to stop working.

(Show only one age)

8. Below, show the average yearly amount (not your total future lifetime earnings) that you think you will earn between now and when you plan to stop working. Include performance or scheduled pay increases or bonuses, but not cost-of-living increases.

If you expect to earn significantly more or less in the future due to promotions, job changes, part-time work, or an absence from the work force, enter the amount that most closely reflects your future average yearly earnings.

If you don't expect any significant changes, show the same amount you are earning now (the amount in 6B).

Future average yearly earnings: (Dollars Only)

\$, .

9. Do you want us to send the *Statement*:

- To you? Enter your name and mailing address.
- To someone else (your accountant, pension plan, etc.)? Enter your name with "c/o" and the name and address of that person or organization.

*"C/O" or Street Address (Include Apt. No., P.O. Box, Rural Route)

Street Address _____

Street Address (If Foreign Address, enter City, Province, Postal Code) _____

U.S. City, State, Zip code (If Foreign Address, enter Name of Country only) _____

NOTICE:

I am asking for information about my own Social Security record or the record of a person I am authorized to represent. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I authorize you to use a contractor to send the *Social Security Statement* to the person and address in item 9.

Please sign your name (Do Not Print)

Date _____ (Area Code) Daytime Telephone No. _____



Social Security Retirement Benefits

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Many people look forward to retirement as a time of contentedness and quiet, a new time for old friendships, a period of calm sufficiency. They imagine they will be able to do things they always wanted to do but never had time for. While this may prove to be a true picture for some people, others find a far different reality. Reduced financial resources make it tough to cope with a high-priced world. In a society that has forgotten how to revere and support its elders, retirement often becomes another difficult siege in the old battle for survival.

The reality for many Americans is that after what they had hoped would be retirement age—usually anticipated as age 65—they must continue working to make ends meet. Often, they end up doing so at lower-paying work than they had before retiring.

The Social Security retirement benefit program, as well as private pension and other retirement plans, helps with some of the financial strain of retirement years. But Social Security retirement benefits alone are not sufficient for most people to live at anything near the standard of living they had during their working years.

These problems bring into question both the age at which you retire and whether you'll continue to work after beginning to collect Social Security. Under Social Security rules, retirement does not necessarily mean you have reached age 65, or that you have stopped working altogether. It merely refers to the time you claim and start collecting Social Security retirement benefits. If you claim benefits before you reach your full retirement age, but continue to work,

the amount of your benefits will be reduced if you earn more than a specific amount of income. (See Section B, below.) Once you reach your full retirement age, however, you will collect the full amount of your retirement benefits no matter how much you continue to earn.

This chapter explains how Social Security figures your eligibility for retirement benefits, when you may and when you should claim the benefits, and what the rules are regarding earnings after you have begun to claim your retirement benefits.

A. Work Credits Required

To be eligible for Social Security retirement benefits, you must have earned the required number of work credits over your working years. (See Chapter 1, Section D, to review how work credits are earned.) You are fully insured—the term Social Security uses to indicate that you are eligible for retirement benefits—if, when you apply for benefits, you have the number of work credits listed below.

Work Credits Required for Social Security Retirement Eligibility

Year You Were Born	Work Credits Required
1929 or later	40
1928	39
1927	38
1926	37
1925	36
1924	35
1923	34
1922	33
1921	32
1920	31

I. Checking Your Earnings Record

Even if you have not worked for many years, and you did not make much money in the few years you did work, check your earnings record. (See Chapter 1, Sections F and G, for instructions on obtaining it.) You may be surprised to find that you have quite a few credits from years gone by, since the rules for getting work credits were pretty easy to comply with before 1978.

If you find that you do not have enough work credits to be eligible for retirement benefits now, you may be able to work part-time for a while and earn enough new credits to become eligible. You've got a high incentive for doing this, because once you qualify for retirement benefits, you are eligible to receive them for the rest of your life. That could mean a lot of money over the years to come.

Example: After graduating from college in 1960, Millie immediately got a good-paying job at a large insurance company. After several years there, she married and stopped working outside the home. Her husband was quite a bit older and had earlier made money in business for himself, and he now supported them both on his investments. After his death in 1970, Millie was able to live carefully on these investments. By the time she was in her 50s, however, Millie found that her assets were dwindling and the monthly income they produced no longer went very far.

When Millie turned 60, she asked Social Security whether she was eligible for survivors benefits (see Chapter 5) based on her husband's work record. But because he had done almost all his work before 1951, (the year self-employment earnings first began to be counted toward Social Security benefits), Millie was not entitled to any survivors benefits.

But Millie also checked her own Social Security work record and found that she had 36 work credits from her time at the insurance company many years before. With 36 credits, she needed only four more to be eligible for her own retirement benefits (born in 1939, she needed a total of 40 credits). She was able to get a part-time job at a local restaurant—the pay was low, but the work allowed her to earn her four additional work credits within a year, qualifying her for Social Security retirement benefits. Even though these benefits were not that much, when added to her income from savings and investments, they made Millie's life much more comfortable.

2. Benefits for Employees of Nonprofits

Before January 1, 1984, nonprofit organizations did not have to participate in Social Security. Some organizations did participate, and their employees' work was covered by Social Security, earning the employees credits just as if they worked for private profit-making employers.

Nonprofit organizations that did not participate, however, paid no Social Security taxes on behalf of their employees, and the employees paid no Social Security taxes out of their wages. As a result, during all their work years before 1984, employees of these nonprofit organizations did not earn any Social Security work credits for their labors.

To help make up for these lost years of work, the Social Security laws permit certain employees of nonprofit organizations to qualify for Social Security benefits with less than the standard number of work credits. If you were at least 55 years old on January 1, 1984, and on

that date were employed by a nonprofit organization that had not been participating in Social Security, you can qualify for retirement benefits with the amounts of work credits, earned after January 1, 1984, listed below.

These special rules do not apply to you if the nonprofit organization gave you the opportunity to participate in Social Security before 1984 but you declined.

**Workers in Nonprofits: Work Credits
Required for Social Security
Retirement Eligibility**

Your Age on January 1, 1984	Work Credits Required
55 or 56	20
57	16
58	12
59	8
60 or older	6

B. Timing Your Retirement

Two factors determine the amount of your retirement benefits. The first is your earnings record: how much you have earned over your working life. The higher your earnings, the higher your benefits.

The second is the age at which you claim your retirement benefits. You are allowed to claim benefits as early as age 62, but the earlier you claim them—up to age 70—the permanently lower the benefits will be. This section explains how the timing of your claim affects the amount of your retirement benefits.

I. If You Claim Benefits Before Full Retirement Age

You're allowed to claim retirement benefits as soon as you turn 62, but don't reach too quickly for your application form. If you claim benefits at 62, your monthly payment will forever be considerably less than if you wait until what Social Security considers your "full retirement" age.

Also, if you claim benefits before your full retirement age but continue to work, your benefits may be significantly reduced if your earnings are over certain yearly limits. (See Section D, below, for these limits.)

The amount by which your benefits would be permanently reduced if you claimed them early depends on the year of your birth and the time between when you claim benefits and when you reach your full retirement age. If you were born in 1937 or earlier, the reduction is about .555% per month, or 6.7% per year, up to a total of 20% if you claim benefits three years early. And, remember, the reduction in monthly benefits is permanent. Benefits do not increase to the full amount when you reach your full retirement age.

Full retirement age will be going up gradually, from 65 to 67, for people born after 1937. For these people, early (and reduced) retirement benefits will still be available at exactly age 62. As you'll notice on the chart below, those born in 1960 or later who retire at 62 will see their benefits shrink by as much as 30%.

Of course, claiming retirement benefits at less than full retirement age means you will collect benefits for a longer time. But the permanent reduction in the amount of your monthly benefits means that if you live past a certain age—in your early 80s, depending on whether you are a

man or a woman and when you were born—you will wind up collecting less in total lifetime benefits than if you had waited until full retirement age.

To get a picture of your reduced benefits, request a Social Security Statement. That statement will include a comparison of your retirement benefits at age 62 and your full retirement age benefits. (See Chapter 1, Sections F and G.)



What if you must retire for health reasons?

Some people are forced to stop working before full retirement age because of ill health. This is particularly true for construction workers and other manual laborers, whose bodies simply start to give out under the strain. If you are under 65 and in that position, consider applying for Social Security Disability benefits rather than early retirement. (See Chapter 3.) The reason is that disability benefits are calculated by the same formula as full retirement benefits, and the amount does not depend solely on the age at which you qualify for them. Be warned, however, that proving you're incapable of doing any sort of work can be a long and difficult process. And even though the benefits calculations follow the same formula, the fact that you've stopped working before your potentially highest-earning years may reduce your benefits amount.

Benefit Reductions for Early Retirement

Year Born	Full Retirement Age	Monthly Reduction	Total Reduction If Claim at Age 62
1938	65 + 2 months	.548%	20.83%
1939	65 + 4 months	.541%	21.67%
1940	65 + 6 months	.535%	22.50%
1941	65 + 8 months	.530%	23.33%
1942	65 + 10 months	.525%	24.17%
1943-54	66	.520%	25.00%
1955	66 + 2 months	.516%	25.84%
1956	66 + 4 months	.512%	26.66%
1957	66 + 6 months	.509%	27.50%
1958	66 + 8 months	.505%	28.33%
1959	66 + 10 months	.502%	29.17%
1960 and later	67	.500%	30.00%

Investing Your Early Retirement Money

Some financial planners suggest that people who are within a year of full retirement age should claim early retirement benefits even if they don't need them for their current support. Although benefits would be reduced by more than 6%, these planners suggest that people can invest the benefits and receive returns of higher than 6%. This would offset the year's reduction and give the claimant an extra year of benefits.

Whether this move is advisable for you depends on your broader financial and health picture. If you are going to keep working and will earn a substantial income during the year, most if not all of the benefits may be cancelled out. (See Section D, below.)

Also, for a year of increased income, you would be trading away a lifetime of higher-percentage benefit amounts. This can add up to a tremendous amount if you live for a long time. And if you are or become dependent on Social Security benefits, the permanent reduction could become quite painful.



Widows and widowers can switch from retirement to survivors benefits. Financial straits force many widow(er)s to claim their retirement benefits at age 62, even though they would become eligible for a higher monthly retirement amount if they waited longer. Although claiming early retirement benefits permanently reduces their retirement benefits based on their own earnings record, Social Security rules permit widow(er)s who have previously claimed early retirement to switch to survivors benefits at age 65. And, for many people, these full survivors benefits are higher than their own reduced retirement benefits. (See Chapter 5 for a full description of survivors benefits.)

The same rules apply to widows as to widowers, although the disparity in earnings between men and women means this ability to switch benefits is used mostly by women.

2. If You Claim Benefits at Full Retirement Age

For a long time, Social Security considered 65 to be full or normal retirement age. Benefit amounts were calculated on the assumption that most workers would stop working full-time and would claim retirement benefits upon reaching age 65.

Now that people are generally living longer, the Social Security rules for what is considered full retirement age are changing. Age 65 is still

considered full retirement age for anyone born before 1938. However, full retirement age gradually increases from age 65 to 67 for people born in 1938 or later.

In addition, to give incentive for people to delay making their retirement claims, Social Security offers higher benefits for people who wait to make their claims until after reaching full retirement age.

Retirement Age for Those Born After 1937

Year Born	Full Retirement Age
1938	65 years, 2 months
1939	65 years, 4 months
1940	65 years, 6 months
1941	65 years, 8 months
1942	65 years, 10 months
1943 - 1954	66 years
1955	66 years, 2 months
1956	66 years, 4 months
1957	66 years, 6 months
1958	66 years, 8 months
1959	66 years, 10 months
1960 or later	67 years

3. If You Claim Benefits After Full Retirement Age

If you wait until after your full retirement age to claim Social Security retirement benefits, your benefit amounts will be permanently higher. Your benefit amount is increased by a certain percentage each year you wait up to age 70.

After age 70, there is no longer any increase and no reason to delay claiming benefits. This is true even if you keep working after you reach full retirement age, since reductions in Social Security benefits because of earned income end when you reach full retirement age. The amount of the yearly percentage increase in benefits depends on when you were born.

Increase per Year in Benefits for Delayed Retirement

Year Born	Percentage Increase
1927 - 1928	4.0
1929 - 1930	4.5
1931 - 1932	5.0
1933 - 1934	5.5
1935 - 1936	6.0
1937 - 1938	6.5
1939 - 1940	7.0
1941 - 1942	7.5
1943 or later	8.0

**Everyone should claim Medicare at age 65.**

Even if you do not claim retirement benefits at age 65, you are eligible for Medicare benefits and must sign up for them then. (In fact, you should submit your application three or four months before your 65th birthday.) Signing up for Medicare does not affect the amount of your retirement benefits. (See Chapter 11 concerning Medicare.)

4. Deciding When to Claim Benefits

Unless your health circumstances leave you no choice but to retire as soon as you can, you may find yourself a bit mindboggled by the different Social Security options. Claim Social Security early, and start using the benefits money as soon as possible, even with the permanently reduced income? Claim Social Security at full retirement age, while wondering whether you could have held out a few more years and gotten higher benefits? Or delay claiming benefits until your late 60s or age 70, gambling that you'll remain on this earth long enough for the higher benefit checks to pay you back for the time when you received no benefits at all?

According to Social Security's formula, the age you choose shouldn't really matter. They have used statistical lifespan figures to calculate benefit amounts so that the average retiree will receive the same total amount of benefits whether he or she first claims them at age 62 or at age 70. You, however, are not a statistic, and may not fit the average. That's why it's impor-

tant to take a realistic look at your life circumstances before deciding when to retire.

a. Your Life Expectancy

Not all of us would want to know in advance when we'll die—but it sure would make Social Security planning simpler. For example, it's easy to see that someone who dies at age 65 would have been better off starting retirement benefits at age 62 than putting off making his or her claim—never mind the permanently reduced benefits. On the other hand, someone who claims early retirement and then lives to 90 may regret not having waited long enough to raise that monthly benefit amount (and lifetime benefits as a result).

If you're like most people, the key financial issue will be the total amount you receive in benefits over your lifetime, which your choice of when to retire may affect. If you knew in advance the age at which you'd die, it would be a simple mathematical calculation to compare the total benefits under the three different retirement age options. Our hypothetical friend who died at 65 having claimed no benefits wouldn't even have needed a calculator—zero dollars versus the several thousand he or she might have received by claiming early retirement is a stark and simple comparison.

For others, however, the comparison will be a little more subtle, and is best analyzed using a concept called the “break-even point.” In Social Security terms, this means the age at which two of your total lifetime benefit amounts become equal to each other—in other words, their totals would be the same whether you claimed earlier or later benefits (at age 62 compared to full retirement age, full retirement age compared to age 70, or even age 62 compared to age 70).

If you can manage to live to your break-even age, your total benefits will be high enough that you, in effect, make up for the lower benefits you received because you didn't wait longer to claim your retirement benefits. If you live longer than your break-even age, the most important figure becomes your monthly benefit amount—and the higher the better.

Example: Helen has just turned 60, and works as an art teacher in a private school. The hours she spends standing and leaning over desks tires her out, but she isn't disabled. She'd love to retire at age 62 and get back to making her own art. The average of Helen's highest earning over her career, for Social Security purposes, is \$35,000. She has good savings and a pension, so she wouldn't need to rely solely on her Social Security benefits if she retired.

Using the calculators available on Social Security's website (www.ssa.gov), Helen finds that if she retires and starts claiming benefits at age 62, she will earn \$775 per month; if she starts claiming benefits at 66 (her full retirement age), she'll earn \$1,080 per month; and if she starts claiming benefits at 70, she'll earn \$1,487 per month. The website also calculates her break-even points, telling her that if she retires at age 62, her break-even point compared to age 66 will be nearly age 76. In other words, if Helen lives until 76, her total benefits received will be the same under either scenario (but if she lives longer, she may regret claiming early benefits with their permanently lowered amounts). That's good enough for Helen; she is in reasonably good health and her parents both lived into their late 70s, so she figures she'll probably live at least until age 76—but she knows that nothing is guaranteed, and her first priority is to be creative during her more productive years. After weighing all the options, Helen decides to retire early.

Of course, if you claim early benefits but then live long past your break-even point, you might reach what we call your “regret point.” In other words, you may regret (with your 20-20 hindsight) not having waited to claim benefits at a higher monthly amount, which it turns out would have meant an overall higher total. If Helen, in the example above, does indeed retire at age 62, but lives to 88, she may experience some twinges of regret at not having waited to claim higher benefit amounts. Then again, she may have enjoyed a wonderful, productive early retirement—these decisions are always intensely personal.



If you have dependents, consider their benefits when choosing your retirement date.

Your family's dependents benefits are based on your retirement benefits amount, and so their benefits will also be reduced if you claim early retirement. That may also result in a reduction of your family unit's overall lifetime benefits.



To calculate your personal break-even points, go to the Social Security website at www.ssa.gov. Click “Calculate your benefits,” then choose among the various calculators. The more information you’re willing to spend time entering, the more advanced a calculator you can use, for more precise results—the Quick Calculator, for example, asks only for your birthdate and current earnings. Or, you can call Social Security at 800-772-1213 and ask them to do the calculations for you.

This brings us to the great unanswerable question of how long you will live. Recent statistics show that men turning 65 in 2001 live, on average, until age 81; while women of the same generation live until age 84. But these statistical averages can only tell you so much. Your own genetics, lifestyle, health, not to mention good or bad luck, will in all likelihood add to or subtract from the average age.

If a health condition makes it likely that you will not live a long life, then claiming early retirement benefits makes sense. You and your family will get to use or save the money, even though it will be at a reduced monthly amount. If, on the other hand, you have no life-threatening medical conditions, your health is generally good, and you have a family history of long life, you may decide to take a chance and delay claiming retirement benefits. With any luck, you will pass your break-even point and collect more lifetime benefits.

b. Your Immediate Financial Need

You may be in a financial situation where you need your Social Security benefits now, regardless of the lower monthly benefits and potentially reduced total lifetime benefits. This may be doubly true if you have one or more qualifying dependents (such as a spouse, child, or grandchild), who can’t claim dependent benefits until you claim your retirement benefits. By claiming benefits early, all of you will receive a new income stream.

Make sure, however, that you also consider the long-term picture in making such a decision. Once you’ve locked in your benefit amount, the only things that can raise it later are a return to work at a relatively high salary, and the relatively small cost-of-living adjustments offered annually by Social Security.

c. The Value of Using Your Benefits Now

Often, the benefits you derive from a financial decision cannot be precisely measured in dollars and cents. For example, buying a new car may not be considered a good investment on paper—the car depreciates in value, while the money you spent on it could have increased in value had you merely stuck it in a savings account. But you get satisfaction, comfort, convenience, and safety from driving the new car. (Economists call this its “use value.”)

By the same token, claiming Social Security benefits early may allow you to do things with your money that you wouldn’t have been able to otherwise. If claiming early also allows you actually stop working, you will free up your time—although claiming benefits doesn’t mean that

you must stop working (see Section D, below, for details).

For example, claiming relatively early Social Security benefits might allow you to travel, invest in a vacation or retirement home, enroll in some classes, or help your grandchildren pay for college—and any of these things sooner than if you had waited until full retirement age to claim your benefits. For Helen, in the example above, it allowed her to be artistically productive in ways she couldn't while working. Any of these might be more important to you than the increased benefits you might gain by waiting to claim benefits.

d. Whether You Plan to Continue Working

Some people are still enjoying productive, stimulating careers at age 62, and have no reason to stop working. Other people would like to quit work but cannot afford to do so. Both may be tempted by the added income that Social Security retirement benefits might offer.

In fact, you can work and claim Social Security benefits at the same time—but at a cost, if you haven't yet reached your full retirement age. As Section D explains, below, you lose \$1 in benefits for every \$2 in income you earn over a low, yearly limit, until you reach full retirement age (at which time you can earn any amount and claim benefits, too, without penalty).

You can probably do the math yourself. First, find out your benefits at age 62 from Social Security, as well as this year's earnings limit. Next, figure out how much you're likely to earn from working. Subtract the annual limit from your projected work income, and divide that amount by two. You've reached the amount that would

be deducted from your Social Security benefits. If much of your benefits would be wiped out by this deduction, claiming early benefits probably doesn't make sense. This is particularly true because your benefits will be permanently lowered by your having claimed them early.

Example: Rajiv is a translator with a local court, earning \$22,000 per year. If he were to claim benefits in 2005 at age 62, they would be \$703 per month, or \$8,436 per year. The yearly earnings limit in 2005 is \$12,000. Rajiv's income is \$10,000 over the limit, so he'd need to divide this amount in half and subtract the result (\$5,000) from his \$8,436 benefit check, leaving him with \$3,436 from Social Security. Rajiv would have to decide whether that amount added to his \$22,000 per year income is worth the lifetime of reduced retirement benefits that would result from his having claimed early retirement benefits.

C. The Amount of Your Retirement Check

Your Social Security retirement benefits depend on how much you earned in covered employment over all your working years. Social Security calculates your benefits based on the amounts in your highest-earning 35 years. Then it applies a set of formulas to these earnings; the exact figures depend on the year you were born.

Social Security's calculations are complex and the results are less than bountiful. For example, the average retirement benefit for someone who reaches full retirement age in 2005 is about \$950 per month. The maximum retirement benefit for someone first claiming benefits in 2004 is \$1,839 per month. Once you claim your

benefits, there is a small cost-of-living increase each year.

Under Social Security's benefit calculation system, the lower your average lifetime earnings, the higher a percentage of those earnings you'll receive in benefits. If your earnings have averaged in the middle range—the equivalent of around \$30,000 in today's dollars—you can expect full retirement benefits of about 40% of your average earnings for the last few years before you reach full retirement age.

If your average earnings have been on the low side—around \$20,000 a year in current dollars—then your benefits will be about 50% of your earnings in the years just before you claim retirement benefits.

If your earnings have always been at or near the maximum credited earnings for each year (see Chapter 1), then your retirement benefits will be about 20% of the maximum amount for the year in which you retire.

But these figures are just averages. To get a much more precise picture of how much your retirement benefits will be, request a Social Security Statement. The closer you are to claiming your benefits, the more accurate Social Security's estimate will be.



Although your official Social Security Statement will give you an estimate of your likely retirement benefits under various scenarios (claiming them at age 62, at full retirement age, or at age 70), you may also want to calculate these estimates yourself online. Go to www.ssa.gov/retire2. Click on "Calculators." This feature additionally allows you to obtain an estimate of your likely retirement benefits if you retire at some other age between 62 and 70.

You'll see three choices for calculating your benefits, offering varying degrees of accuracy. The first, called the "Quick Calculator," is the roughest. It bases its calculation solely on your current earnings and assumes that you've earned at a steadily increasing rate between age 22 and now. If these assumptions are false, the estimate will be out of whack as well.

Your second option is called the "Online Calculator." It requires more work: You'll have to get a copy of your Social Security Statement and transfer your earnings figures by hand into the online calculator. Once you've done so, however, you'll get estimates of your retirement benefits that are as accurate as those on your Social Security Statement—and you'll get them for any year you choose.

If you want all the possible bells and whistles, a "Detailed Calculator" can be downloaded and installed on your own computer. (Check your hardware capacity first.) This offers the exact same calculation as the Social Security Administration itself uses to determine your benefits. However, even this calculator is not the last word on the matter—if more than a year passes between your calculation and filing your claim, the actual benefit figures may change.

**Benefits for Notch Babies:
People Born 1917 to 1921**

People born between 1917 and 1921—a period referred to as the “notch”—receive slightly smaller benefits than some people with comparable earnings records who were born before 1917.

For a few years in the 1970s, people born earlier—from 1910 to 1916—were actually given benefits that were too high. When the mistake was corrected, the people born in that period were just retiring. Congress did not want to reduce the benefits of the 1910 to 1916 people too abruptly, so they permitted them to keep the extra high benefits. People born in the notch, however, had their future benefit amounts reduced to the correct levels, the same levels as applied to people born later.

While notch people may get a little less than people born slightly earlier, they are not being deprived of their proper benefit amounts. Rather, the people born earlier are receiving a small windfall amount.

1. Increases for Cost of Living

Whatever the amount of your retirement benefit, you receive an automatic cost-of-living increase on January 1 of each year. This increase is tied to the rise in the Consumer Price Index: the cost of basic goods and services. In the late 1970s, this Consumer Price Index rose more than 10% each year, causing Social Security benefits to rise more than 10% per year. In the 1980s, however, the yearly cost of living increase began to drop. In 2005, for example, the increase was only 2.7%. You cannot be sure that your benefit

amounts will increase at any set pace, although they should be increased by some amount every year, no matter how long you continue to collect benefits.

**2. Reductions for
Government Pensions**

Many people have worked both at government agency jobs and at jobs covered by Social Security. And some have worked long enough in each that they have earned the right not only to Social Security retirement benefits, but also to a public employee retirement system pension.

Social Security calculates its benefits based on an average of earnings over 35 years. However, if you had many years in employment with low wages, Social Security will artificially adjust your benefits upward. Also, if you spent years in public employment, Social Security used to consider these as nonincome years, which made you eligible for the artificially raised retirement benefits.

Social Security has now decided that if you earned a government pension during those years, your artificially raised benefit amount was an unfair windfall to you. And so your benefits have been reduced.

a. Those Covered

If your age and work history fit certain categories, your Social Security check will be reduced by 10% to 35% because of this windfall. You may be affected by this reduction if:

- you were born in 1924 or after

- you first became eligible in 1986 or after for a government pension, and
- you have less than 30 years in work covered by Social Security.

b. Those Not Covered

The windfall reduction does not affect you if:

- your only work for an employer not covered by Social Security was before 1957
- your only government pension is based solely on work for the railroad, or
- you were a federal government employee hired on January 1, 1984 or after.



Government pensioners seeking spouse's benefits may face limits. Another rule limits benefits to people who collect both Social Security benefits as the spouse of a retired or deceased worker and public employment pensions based on their own work records. (See Chapter 4, Section E, and Chapter 5, Section F, for details.)

D. Working After Claiming Retirement Benefits

Since Social Security retirement benefits plus savings and other investments are often not enough to live on comfortably, many people keep working for at least a few years after they claim Social Security retirement benefits. Other

people keep their jobs or take new ones, to stay active and involved in the world of work. And if you keep working at a high enough salary, you may increase your lifetime earnings average, thereby slightly increasing your benefits for the years to come.

If you plan on working after early retirement (age 62 to 65), be aware that the money you earn may cause a reduction in the amount of your Social Security retirement benefits. (It's a temporary reduction, for as long as you keep working until your full retirement age.)

I. Reductions Based on Earned Income

Until you reach full retirement age, Social Security will subtract money from your retirement check if you exceed a specific amount of earned income for the year. The term "earned income" refers only to money received for work you currently do. Earned income does not include:

- interest on savings or investments
- capital gains (profits from the sale of stock or other assets)
- IRA or 401(k) withdrawals
- insurance cash-ins
- rental income, or
- private pensions.

This rule favors the well-to-do who have significant income from these sources, as opposed to wages or salary from current work. Those who need to keep on working, on the other hand, are penalized by having their retirement benefit reduced if they earn over the specific limits.

Certain types of money you receive from work performed before you claimed retirement benefits—known as special payments—are not counted by Social Security as earned income. Special payments exempted by Social Security include:

- bonuses
- accumulated vacation pay or sick leave compensation
- retirement funds
- deferred compensation, and
- accumulated commissions.

If you are self-employed, Social Security does not count special payments you receive more than one year after retirement for services you performed before retiring.

2. Earned Income Without Penalty

The amount of income you're allowed to earn without losing a portion of your Social Security retirement benefits depends on:

- your age, and
- yearly changes in the amounts allowed.

In the year 2005, for example, the limits on earned income are \$12,000 per year until you reach full retirement age. (At retirement age, there is no limit at all on the amount you can earn and still receive your full Social Security retirement benefit.)

If you are under full retirement age and you earn income over the year's limit, your Social Security retirement benefits are reduced by one

dollar for every two dollars earned over the limit.



You can collect retirement benefits plus unemployment benefits. As this chapter explains, you may continue to work even after you begin claiming your Social Security retirement benefits. If you are working and you lose your job, you may collect unemployment benefits (assuming you otherwise qualify for them) even though you are also collecting your Social Security retirement benefits.

3. Special Rule as You Approach Full Retirement Age

If you are already receiving your retirement benefits, a special higher earnings limit applies in the 12 months while you're approaching full retirement age. If you will reach full retirement age in 2005, you may earn up to \$2,650 per month without losing any of your benefits. For every \$3 you earn over that amount in any month, you will lose \$1 in Social Security benefits. Beginning in the month you turn 65, you become eligible to earn any amount without penalty.

If you are self-employed, you may receive full benefits for any month during this first year in which you did not perform what Social Security considers substantial services. The usual test for substantial services is whether you worked in your business more than 45 hours during the month.

Change in How You Report Earnings

The Social Security Administration recently changed its rules about when and how benefit recipients under full retirement age must report yearly earnings. The Social Security Administration now bases its benefit calculations on earnings reported on W-2 forms or self-employment tax payments. (Individual benefit recipients are no longer required to send in an estimate of earnings by April 15 of each year.)

The Social Security Administration still requests earnings estimates from some beneficiaries: those with substantial self-employment income or whose reported earnings have varied widely from month to month, including people who work on commission. Toward the end of each year, Social Security sends those people a form asking for an earnings estimate for the following year. The agency uses the information to calculate benefits for the first months of the following year. It will then adjust the amounts, if necessary, after it receives actual W-2 or self-employment tax information in the current year.

Once a beneficiary reaches full retirement age, his or her income will no longer be checked. Since there is no Social Security limit on how much a person can earn after reaching full retirement age, there is nothing to report.





Social Security Disability Benefits

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Over five million disabled workers and their families receive Social Security disability benefits. Many of these people developed their severe injuries or illnesses when they were not old enough to collect retirement benefits. Or, even if they had already reached retirement age, they may not have had enough work credits to qualify for retirement benefits. In both situations, Social Security disability benefits provided an answer.

If you find it difficult to work because of a physical or emotional condition that is not likely to resolve itself within a year—and you are short of retirement age—read this chapter carefully. If you have enough work credits for your age, you may be eligible for monthly disability benefits. And if you are eligible to receive disability benefits, your spouse and minor or disabled children may also be eligible to collect benefits. (See Chapter 4, Section A, regarding dependents benefits.)

A. Who Is Eligible

Social Security disability benefits are paid to workers and their families only when the worker has enough work credits to qualify. Work credits for disability benefits are calculated in the same way as for retirement benefits, although fewer credits are required to qualify for the disability program. A person can earn up to four work credits per year, and anyone who works full time, even at a very low-paying job, easily accumulates them. (See Chapter 1, Section D, for a discussion of how work credits are earned.)



This chapter will introduce you to Social Security disability benefits. But there's much more to know about the subject, particularly when it comes to convincing the Social Security Administration that a particular disability makes you unable to work. [Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits](#), by David A. Morton III, M.D., (Nolo), will give you a much fuller explanation. It includes details on whether you might qualify for benefits, how to apply, how to keep existing benefits, and how to work while you're still receiving benefits.

I. Work Credits Required

The number of work credits you'll need in order to qualify for disability benefits depends on your age when you become disabled.

There are two ways to qualify for disability benefits—or be “fully insured,” in Social Security lingo. You must:

- have one or more work credits for each year between 1950 and the year you become disabled or reached age 62, or
- have one or more work credits each year from the year you turned 21—if that was after 1950—until you become disabled or turn 62.

At least six credits are always required, and no one is required to have more than 40.

Example: Eunice was born in 1947 and became disabled in 2005. To qualify for disability benefits, she needs one work credit for each of the 37 years between 1968 (the year she turned 21) and 2005, the year she became disabled.

The charts below provide a quick reference to see how many work credits you need to qualify for disability benefits.

There are also rules that make it easier for younger workers and people who become blind to qualify for disability benefits. (See Sections 3 and 4, below.)

Work Credits Required to Qualify for Disability Benefits

If you were born before 1930
and you became disabled
before age 62 in:

You need this many
work credits:

1980	29
1981	30
1982	31
1983	32
1984	33
1985	34
1986	35
1987	36
1988	37
1989	38
1990	39
1991 or later	40

If you were born after 1929
and you became disabled
at age:

You need this many
work credits:

31 to 42	20
44	22
46	24
48	26
50	28
52	30
54	32
56	34
58	36
60	38
62 or older	40

Help From the Americans with Disabilities Act

A federal law, the Americans with Disabilities Act, or ADA, prohibits employment discrimination on the basis of a worker's disability. The ADA is intended to help people with disabilities who want to work but are frustrated by noncooperative employers.

In general, the ADA prohibits employers from discriminating against disabled people when hiring, promoting, and making other job decisions. It also tells employers to maintain a workplace that doesn't have substantial physical barriers to people with disabilities. The ADA requires that employers make reasonable accommodations for qualified workers with disabilities, unless that would cause the employers undue hardship.

Unfortunately, the ADA is full of vague language. Disability rights advocates, lawyers, employers, and courts are still wrangling over precisely what terms like "reasonable accommodations" and "undue hardship" mean. And given the current antiregulation climate in government, it is not clear how strenuously the government or the courts will enforce the law. All in all, it is difficult to say how effective the law will be in the coming years in assisting people to keep working despite their disabilities.

For information about how the ADA is being enforced and where you can go for help in seeking its protection, contact the Office on the Americans with Disabilities Act in the Civil Rights Division of the U.S. Department of Justice at 800-514-0301 (voice) or 800-514-0383 (TDD). The Justice Department also has an ADA website at www.usdoj.gov/crt/ada/adahom1.htm. For help and referrals from an activist disabled citizens action group, contact the Center for Independent Living in Berkeley, California, at 510-841-4776 or 510-848-3101 (TDD), or see its website at www.cilberkeley.org.

2. Requirement of Recent Work

You must have earned at least 20 of the required work credits within the ten years just before you became disabled, unless you qualify under one of the special rules for young or blind disabled workers.

Example: Monica worked for ten years before she had children, earning 40 work credits during that time. After her children were in high school, she went back to work. That was in 2001, and, at the beginning of 2005, she became disabled with a back injury.

Although she had more than the 40 total credits required for disability benefits, she could not collect them at the beginning of the year because she had only worked four years—earning 16 credits—within the ten previous years (1995 to 2005). She needed to work long enough to earn four more credits before she could qualify for disability benefits. In 2005, that meant she had to earn \$3,680 during the year (four credits at \$920 per credit) before she could qualify.

3. Young Workers

If you were disabled between the ages of 24 and 31, you need only half of the work credits you could have earned between age 21 and the time you became disabled. And if you were disabled before age 24, you would need only six credits in the three-year period immediately before you became disabled. These special rules exist because workers who become disabled at a young age obviously do not have the opportunity to acquire many work credits.

Example: Boris became disabled at age 29. There were eight years between when he was age 21 and the time he became disabled. During those years he could have earned 32 work credits: four per year. Under the special rule for young workers, however, Boris needs only half, or 16 credits, to qualify for disability benefits.

4. Blind Workers

If you are disabled by blindness, you must have the same number of work credits as anyone else your age. (See Section A1, above.) However, you need not have earned your work credits within the years immediately preceding your disability, as required for other workers. Your work credits can be from any time after 1936—the year the Social Security law went into effect.

For purposes of Social Security disability benefits, being blind means having no better than 20/200 vision in your better eye with glasses or other corrective lens, or having a visual field of 20 degrees or less. (See Section B, below, for more information on blindness as a disability.)

5. Disabled Widows and Widowers

If you are a widow or widower age 50 or older and disabled, you may receive disability benefits even though you do not have enough work credits to qualify. The amount of these benefits depends entirely upon your deceased spouse's average earnings and work record. Because they are based on a spouse's work record, these benefits will end if you remarry.

You must also meet a number of qualifications:

- You must be disabled, as defined by Social Security rules. (See Section B, below, for more on these rules.)
- Your spouse, at death, must have been fully insured—meaning he or she had enough work credits to qualify for disability benefits based on his or her age.
- Your disability must have started no later than seven years after your spouse's death.
- If you already receive Social Security benefits as a surviving widow or widower with children, your disability must have begun no later than seven years after your child or children become adults, causing those benefits to end. (See Chapter 5, Section A, regarding survivors benefits.)
- If you divorced before your former spouse died, you will be eligible for these benefits only if the two of you were married for ten years or more.

B. What Is a Disability

To receive Social Security disability benefits, you must have a physical or mental disability that both:

- is expected to last, or has lasted, at least one year, or to result in death, and
- prevents you from doing any substantial gainful work.

Of course, several of the terms within these definitions are subject to different interpretations. This section explains some guidelines developed by Social Security and the courts regarding qualifications for disability.

I. Conditions That May Qualify

Social Security keeps a list of common conditions it considers disabling. (See Section B2, below.) And the medical community has a tendency to treat more seriously the things it can easily name. But every person's physical and mental state is different, and the human mind and body can be very complex. So you may well have a condition that prevents you from working but is difficult to get doctors to name and describe. Don't let that discourage you from filing for disability benefits.

The only absolute rule regarding disability is that the condition which prevents you from working at gainful employment must be a "medical" one, meaning that it can be discovered and verified by doctors. It does not have to be a simple one that can be immediately given a name. If you are considering making a claim for disability benefits, examine the requirement that the disability must prevent you from performing substantial gainful work (as explained in Section B4, below). Discuss the matter thoroughly with your doctor or doctors.

If the people who have treated you for your condition do a good job of describing it, with the substantial gainful employment rule in mind, any physical or mental medical condition can qualify you for benefits if it is truly disabling. (How to organize and present your application is discussed in Chapter 7.)

2. Listed Impairments

To simplify the process of determining whether a disability makes a person eligible for benefits, Social Security has developed a list of common serious conditions that it usually considers dis-

abling. If you prove, through medical records and doctors' reports, that you have one of the listed conditions—paralysis of both an arm and a leg, for example—Social Security will likely consider you eligible for benefits without making you prove that you cannot perform substantial gainful work and that the condition will last a year. If you have one of the listed conditions, Social Security will simply assume that you are eligible.

The more common serious conditions that Social Security normally considers disabling are listed below. Every person's claim for disability is considered individually, however, and having a condition on this list does not automatically qualify you for disability benefits. You must have medical verification—from a doctor or hospital that has treated you—of the condition that appears on the list. If you do, your application for disability benefits is likely to be approved unless you have been working since you became disabled. If you have been working, Social Security will determine whether your condition prevents you from performing what it defines as substantial gainful work.

A select few of the conditions Social Security lists as being disabilities include:

- diseases of the heart, lung, or blood vessels resulting in a serious loss of heart or lung reserves as shown by X-ray, electrocardiogram, or other tests—and, in spite of medical treatment, causing breathlessness, pain, or fatigue
- severe arthritis causing recurrent inflammation, pain, swelling, and deformity in major joints so that the ability to get about or use the hands is severely limited
- mental illness resulting in marked limiting of activities and interests, deterioration in per-

sonal habits, and seriously impaired ability to get along with other people, such that it prevents substantial gainful employment

- damage to the brain, or brain abnormality resulting in severe loss of judgment, intellect, orientation, or memory
- cancer which is progressive and has not been controlled or cured
- Acquired Immune Deficiency Syndrome (AIDS) or any of its related secondary diseases, causing an inability to perform substantial gainful employment
- diseases of the digestive system that result in severe malnutrition, weakness, and anemia
- loss of a leg, or a disease or injury that has made one leg completely useless
- loss of major function of both arms, both legs, or a leg and an arm
- serious loss of function of the kidneys, and
- total inability to speak.

The full listings are found in the Code of Federal Regulations (C.F.R.) Title 20, Part 404, Subpart P, Appendix 1.

3. Must Be Expected to Last One Year

No matter how seriously disabling a condition or injury is, it will not make you eligible for disability benefits unless it has lasted, or is expected to last, one year. The disability will also qualify if it is expected to cause death within a year.



Apply for benefits upon diagnosis. Even though the disability must be expected to last at least a year, you do not have to wait the year to apply for benefits. As soon as the condition is disabling and a doctor can predict that it is expected to last a year, you may qualify. (The application process is described in Chapter 7.)

Example: Ladonna fell down some stairs and dislocated her hip. She was placed in a body cast and was told by her doctor to stay in bed for three to four weeks. The cast would stay on for four months. After that, Ladonna would need a cane for another two or three months. In six to nine months, she would be walking normally again, although a little bit more cautiously, particularly around stairs. She would be off work for a total of seven or eight months.

Despite the seriousness of her injury and her total inability to work while she recovered, Ladonna cannot claim Social Security disability benefits. The reason is that her disability was not expected to last for a year. However, she might qualify for her company's disability benefits, if the company provides them, or for unemployment or state disability compensation through her state's employment or disability office.

If, after you begin receiving benefits, it turns out that your disability does not actually last a year, Social Security cannot ask for its money back. You are not penalized for recovering sooner than expected, as long as the original expectation that the disability would last a year was expressed in writing by your doctor and accepted by the Social Security review process.

Example: Ravi had a stroke, leaving most of his left side paralyzed. He was unable to walk on his own, was unable to speak clearly, and needed help with most simple daily life tasks. He began physical and speech therapy, but his doctors predicted that he was unlikely to recover full use of his left arm and leg. Ravi was found eligible for disability benefits because his condition was totally disabling and it was not expected that within a year he would recover sufficiently to return to work. However, through hard work, Ravi recovered both his speech and enough of the use of his arm and leg to return to work in ten months.

Although his total disability did not last the required year, he was able to keep the disability payments he had already received because the doctors had expected that his condition would be totally disabling for at least a year and the Social Security disability review process had accepted that prognosis.

4. No Substantial Gainful Work

To be eligible for Social Security disability benefits, you must be unable to perform any substantial gainful work—considered to be any work from which you earn \$830 per month or more.

In determining whether your condition prevents you from doing substantial gainful work, Social Security will first consider whether it prevents you from doing the job you had when you became disabled, or the last job you had before becoming disabled. If your disability prevents you from performing your usual job, Social Security will next decide whether you are able to do any other kind of substantial gainful work—that is, any job in which you could earn \$830 per month or more.

As part of this determination, Social Security considers your education, training, and work experience. For example, a highly trained professional, whose work does not require any physical exertion but which is highly compensated, may still be able to earn \$830 a month despite a certain physical disability. However, someone whose entire working life has been in lower-skilled, lower-paying work that requires considerable physical labor might have a harder time earning \$830 per month with exactly the same physical disability.

Age is also taken into consideration. Social Security realizes that it won't be committing to as great an outlay of money when it grants disability benefits to people nearing retirement age as it does to younger workers. The older workers were on the brink of collecting retirement benefits anyway. For this reason, and because it is more difficult for older workers to find new employment or to retrain for other kinds of work, Social Security tends to approve their disability claims more readily than those of younger workers.

Finally, Social Security will determine whether you are able to perform any kind of work for pay existing anywhere in the economy, whether or not there are actually any such jobs available in the area in which you live. However, it is up to Social Security to prove that there is gainful employment you can perform. It is not up to you to prove there is no work you can do. Once you have shown that you are unable to do your usual work, Social Security is responsible for the rest.

5. Blindness

If your vision is no better than 20/200 with correction, or if your field of vision is limited to 20 degrees or less, you are considered blind under Social Security disability rules. Assuming that your work credits add up to the required amount for your age, you (and your family) can receive disability benefits.

Some blind persons are able to continue working, at least part time, while simultaneously collecting benefits. If you are blind you can earn up to \$1,380 per month—the amount increases from year to year—before your job is considered substantial gainful work that would disqualify you from benefits.

If you are between ages 55 and 65 and blind, it is easier to qualify for disability benefits. The key is to show that you are unable to perform work requiring skills or abilities comparable to those required by the work you did before you turned 55 or before you became blind, whichever was later. This level of performance is measured by whether you work at the kind of job you previously had and you earn more than \$1,380 every month. If you earn that much occasionally but not every month, you can still qualify for benefits. Checks will be withheld, however, for any month in which you do perform substantial gainful work—that is, earn over \$1,380.

Applying Protects Your Retirement Benefits

If you are legally blind, earning too much money to qualify for disability benefits, but also earning significantly less than before your blindness, you may want to apply for benefits. In this situation, Social Security can put what is called a “disability freeze” on your earnings record to protect your overall average.

The amount of your retirement benefits, or of your disability benefits if you later qualify, is determined by your average income over the years. (See Chapter 1, Section E, for further explanation.) If, because of your disability, you are now making considerably less than you were before, these lower earnings will pull your average income lower, resulting in a lower ultimate Social Security payment. The disability freeze permits you to work and collect your lower income without having it figured into your lifetime average earnings.

6. Examples of Disability Determinations

The following examples help illustrate Social Security’s reasoning in applying its guidelines and making disability determinations.

a. Unsuitability for Other Work

Example: Arnold has been a longshoreman for most of his life. At age 58, his back has been getting progressively worse. His doctor has told him that continuing to do longshore work won’t be possible much longer. The doctor also says that

sitting for any length of time will aggravate the condition. Arnold applies for disability.

Since there is no question that Arnold’s condition will last more than a year, Social Security will next ask whether it prevents Arnold from performing substantial gainful activity. Arnold’s back prevents him not only from doing his regular job or other physical labor, but also from sitting for long periods of time. Unless Social Security can describe a job which requires neither physical labor nor sitting, Arnold would probably get disability payments. And because Arnold has done physical labor all his life, he may not have the training, work experience, or education to do many other jobs. Considering his age and the difficulty finding any type of work for which he could be retrained, it is likely that Social Security would find him eligible for disability benefits.

b. Two Conditions Combined

Example: Ernestine has been a music teacher for many years. She is now 60 years old and is losing her hearing. She has also developed phlebitis, which makes it difficult for her to walk very far or to stand for long periods of time. She has to elevate her legs for a while every few hours. When her hearing loss makes it impossible for her to continue teaching music, she applies for disability benefits.

The combination of her two conditions may make her unable to maintain any gainful employment. She would have to find a job which required neither good hearing nor standing, and permitted her to put her legs up for a half hour several times a day. Since such jobs are scarce, Social Security would very likely find Ernestine eligible for disability, particularly in light of her age.

c. Mild Disability

Example: Rebecca is 52 and has a mild heart condition. Despite medication, she has intermittent fatigue and shortness of breath, especially at her job as a waitress. Her doctor says that her work is too physically demanding and stressful for her heart. Rebecca applies for disability benefits.

While Rebecca's condition—disease of the heart leading to breathlessness and fatigue despite medication—is on Social Security's listing of impairments, she is not automatically eligible for disability benefits. Her condition is mild enough that she could probably find new and different work. If Rebecca had training or experience doing any other kind of work, she would almost certainly be required to look for a job elsewhere. Even if she had no other developed job skills, because of her relatively young age, she probably would be required to train for some other type of work.

C. Amount of Disability Benefit Payments

Disability benefits are available both for individual disabled workers and for their families: spouses and minor or disabled children. The maximum amount for worker and family combined is either 85% of what the disabled worker was earning before becoming disabled, or 150% of what the worker's individual benefit would be, whichever is lower.

But this is the maximum, and like other Social Security benefits, the amount of your actual disability check is determined by your age and

your personal earnings record: your average earnings for all the years you have been working, not just the salary you were making most recently.

Example: Manu was making \$3,200 a month when he became disabled at age 56. At that time, Manu's Social Security earnings record would have given him an individual disability benefit of \$900 a month. But Manu's wife and teenage daughter are also eligible to collect dependents benefits. Their total family benefits would be the lower of 85% of Manu's \$3,200 monthly salary, which comes out to \$2,720, or 150% of what Manu's individual disability benefit (\$900) would be, which comes out to \$1,350. The family would receive \$1,350 a month, the lower of the two amounts.

I. Estimating Benefit Amounts

There is no simple formula for what your actual disability payments will be. Although some books and magazines print tidy charts matching age and income with disability benefit amounts, more often than not these charts mislead people, causing them to overestimate their benefits. The charts all base their figures on your current earnings and assume that you have had a consistent earning pattern during your entire working life. Since most people do not have such a perfect curve of earnings, however, the estimates the charts give you are bound to be wrong.

You can get a general idea of disability benefits amounts by considering average payment amounts from 2005.

Estimated Disability Benefits for 2005

Average Annual Lifetime Income in Current Dollars	Monthly Benefits
\$10,000 to \$20,000	\$500 to \$750 (individual) \$850 to \$1,050 (couple or parent and child)
\$20,000 to \$30,000	\$700 to \$1,000 (individual) \$1,100 to \$1,500 (couple or parent and child)
\$30,000 and up	\$1,000 to \$1,800 (individual) \$1,500 to \$2,300 (couple or parent and child)



Check your eligibility for supplemental

benefits. If you receive only a small disability benefit, and you have savings or other cash assets of less than \$5,000, you may be eligible for Supplemental Security Income benefits (SSI) in addition to your Social Security disability benefits. (See Chapter 6 regarding SSI.)

Stopping with general estimates of disability benefits makes little sense, because you can get a very accurate estimate, based on your exact earnings record, directly from Social Security. You can get this estimate either when you apply for benefits or by requesting a Social Security Statement. (See Chapter 1, Sections F and G, for instructions on requesting and interpreting your Statement.)

2. Cost of Living Increases

Monthly disability benefit amounts are based entirely on your personal earnings record, with no consideration given to the minimum amount you need to survive. Whatever your monthly amount, however, there is a yearly cost of living increase based on the rise in the Consumer Price Index; in recent years, the increase has been only 1% to 4%.



Don't expect to start receiving disability benefits right away. Applying for disability benefits and proving your disability can be a slow, sometimes difficult business. You need to organize your paperwork, have the cooperation of your doctors, and be patient and persistent. What to expect in the application process and how best to prepare for it are discussed in Chapter 7.

D. Collecting Additional Benefits

Since disability payments are often not enough to live on, it is important for you to collect all the other benefits to which you may be entitled. You may even want to try to supplement your income by working to the extent you can.

I. Disability and Earned Income

Your benefit check will not be reduced if you earn income while collecting Social Security disability benefits. However, if you regularly earn enough income for your work to qualify as gainful employment, you might not be considered disabled any longer and your benefits could be cut off entirely.

It is possible, though, to earn a little money and still remain eligible for disability benefits. Social Security usually permits you to earn up to about \$830 a month—\$1,380 if you are blind—before you will be considered to be performing substantial gainful work. Also, in deciding how much you are earning, Social Security is supposed to deduct from your income the amounts of any disability-related work expenses, including medical devices or equipment such as a wheelchair, attendant care, drugs, or services required for you to be able to work. It will be up to you to prove such expenses.

The \$830 per month amount is not fixed. You cannot simply keep your income below this level and expect that your disability benefits will automatically continue. Both your physical con-

dition and the amount of your work will be reviewed periodically. (See Section E, below, regarding periodic reviews.) This review will take into account the amount and regularity of your income, your work duties, the number of hours you work, and, if you are self-employed, the extent to which you run or manage your own business.

If you are working long hours or have significant work responsibility, particularly if you are in business for yourself, Social Security will look hard, during its review of your disability status, at whether the \$830 income limit is a true measure of your work. If, for example, family members are suddenly earning quite a bit more than they used to from the business, Social Security may suspect that you are doing the work and simply paying them instead. Or, if you are not getting paid much but you are working long hours for a business in which you have an ownership interest, they may look more closely at whether you are still disabled.

2. Other Social Security Benefits

You are not permitted to collect more than one Social Security benefit—retirement, dependents, survivors, disability—at a time. If you are eligible for more than one monthly benefit based either on your own work record or on that of a spouse or parent, you will receive the higher of the two benefit amounts to which you are entitled, but not both. Supplemental Security Income (SSI) is an exception; you may collect SSI in addition to any other Social Security benefit. (See Chapter 6 for more on SSI.)

3. Other Disability Benefits

You are permitted to collect Social Security disability benefits and, at the same time, private disability payments from an insurance policy or coverage from your employer. You may also receive veterans (VA) disability coverage at the same time as Social Security disability benefits. (See Chapter 10 for a full discussion of VA benefits.)

4. Workers' Compensation

You may collect workers' compensation benefits—payments for injuries suffered during the course of employment—at the same time as Social Security disability benefits. Workers' compensation benefits are paid only until you recover, or until your injuries are determined to be permanent, at which time you receive a lump sum compensation payment.

While you are receiving monthly workers' compensation, the total of your disability and workers' compensation payments cannot be greater than 80% of what your average wages were before you became disabled. If they are, your disability benefits will be reduced so that the total of both benefits is 80% of your earnings before you became disabled. If you are still receiving Social Security disability benefits when your workers' compensation coverage runs out, you can again start receiving the full amount of your Social Security benefits.

Example: Maxine became disabled with a back condition while working as a gardener and earning \$1,400 a month. Her Social Security disability benefits were \$560 a month, and, because her disability was related to her job, she also received

workers' compensation benefits of \$625 a month. The total of the two benefits was more than 80% of her prior salary (the combined benefits of \$560 and \$625 total \$1,185, and 80% of \$1,400 is \$1,120), so her disability benefits were reduced by the extra \$65, down to \$495 a month.

If Maxine was still disabled when her workers' compensation benefits ended, her Social Security disability benefits would go back up to \$560 a month, plus whatever cost of living increases had been granted in the meantime.

5. Medicare

After you have collected disability benefits for 24 months—and those months need not be consecutive—you become eligible for Medicare coverage. This is true even if you are not age 65, which is otherwise the standard age to qualify for Medicare. Medicare hospitalization coverage is free. However, you must pay a monthly premium if you want to be covered by Medicare medical insurance. (See Chapter 11 for a full discussion of Medicare.)

6. Medicaid and SSI

If you have few or no assets—or your disability and the resulting medical costs deplete your assets and hamper your ability to earn income—you may qualify for Medicaid coverage. Medicaid is a program of government medical coverage available to people based on their low income and assets, excluding their home. You may be eligible for Medicaid coverage as soon as you qualify under its rules, without the 24-month wait Medicare requires. And even when you do

qualify for Medicare, Medicaid can continue to pay medical bills that Medicare won't. (See Chapter 15 for a full discussion of Medicaid.)

If you qualify for Medicaid assistance, you may also qualify for cash payments from the SSI program, on top of your Social Security disability benefits. Like Medicaid, SSI is intended to assist people with low income and assets. (See Chapter 6 for more on SSI.)

Protecting Your Medicaid Eligibility

Qualifying for Medicaid requires that you have very few assets. (See Chapter 15 for Medicaid eligibility requirements.) The same is true for government-assisted housing and other government benefit programs.

But if your disability was caused by an accident that was someone else's fault, you may have a chunk of money coming to you as the result of an insurance claim or a lawsuit. Receiving that money, however, might disqualify you from Medicaid and eligibility for other benefits, which would mean you'd have to spend it all on future medical bills, with nothing left for other living expenses.

Federal law and the laws of many states address this problem by allowing you to set up a "Special Needs Trust." This permits you to accept accident compensation without losing your Medicaid and other benefit eligibility. With such a trust, instead of the accident compensation going to you in a lump sum, it is held for you by a bank or similar institution and is used to pay only certain types of bills—usually medical and basic living expenses. If your situation requires a Special Needs Trust, consult an experienced estate planning lawyer for help.

E. Review of Your Eligibility

Eligibility for disability benefits is not necessarily permanent. Depending on the nature and severity of your condition, and on whether doctors expect it to improve, Social Security will periodically review your condition to determine whether you still qualify for benefits.

I. When Your Eligibility Will Be Reviewed

If, when you apply for disability benefits, your doctors and Social Security's medical experts expect that your condition will improve, your eligibility will be reviewed six to 18 months after you apply for benefits. If improvement in your condition is theoretically possible but not predicted by the doctors, Social Security will review your eligibility approximately every three years. If your condition is not expected to improve after you apply, Social Security will review your case every five to seven years.

If at any point after you are receiving disability benefits you earn a steady or frequent monthly income of close to \$810 a month, Social Security may also call you in for a review. The agency will determine whether you are actually able to perform substantial gainful employment for more than \$810 per month. It will do this by comparing the work you are doing with other, similar work in your geographic area. It must be work that you could do and that is actually available. Social Security will also check to see whether you are arranging to be paid less than \$810 per month by having someone close to you receive money for your work, or whether you are being paid in some way other than cash wages or salary.

2. The Review Process

The first step in a review of your eligibility for disability benefits is a letter from Social Security summoning you to a local office for an interview. The subject of the interview will be your medical condition and any work you are doing. You should bring with you the names and addresses of the doctors, hospitals, and other medical providers you have seen since your original eligibility was established, or since your last review. You should also bring with you information about any income you are currently earning—including where you work, how much you earn, and the person to contact at your place of employment.

The local Social Security office service worker will ask you about your condition and work, and will then refer your file to the Disability Determination Services (DDS), the special agency that reviews all disability claims. (See Chapter 7, Section B3.)

The DDS will obtain your current medical and employment records and may again ask that you undergo a medical consultation or examination. (See Chapter 7, Section B3b, for more on the disability determination process.) The DDS will make a determination about your continued eligibility based on the medical records and reports and on your earned income. Unless your condition has substantially improved, or you have regularly been earning more than \$810 per month, or you are found to be doing substantial gainful employment despite being paid less than \$810 a month, your benefits will continue.

If your eligibility is terminated, you have a right to appeal that decision. (See Chapter 8 for a full discussion of the appeal process.) And if you lose your eligibility, benefits can continue for an adjustment period of up to three months

while you look for work and wait for a paycheck. (See Section F, below.)

F. Returning to Work

Most disabled people would rather work than not, and many try to find ways of working despite their disabling conditions. Social Security provides various forms of encouragement for people to return to work. For example, they ensure that people will continue to receive their disability benefits during time they spend testing the workday waters. And if, after returning to work, a person later finds that his or her disability just makes the work too much to continue with, the person's disability benefits can be restarted quickly and easily.

I. Trial Work Period

Within any five-year period, you may try out some kind of work—and keep any income you earn—for up to nine months while still receiving full disability benefits. (Your medical condition must still qualify you as disabled during this trial period.) You may try one job for a month or two and, if it doesn't work out, attempt the same or another job sometime later—up to a total of nine months within any five-year period. These nine months do not have to be consecutive.

2. Extended Eligibility for Benefits

After you have worked for nine months—the trial work period—during a five-year span, Social Security gives you another 36-month period of eligibility during which you can continue to work without necessarily losing your eligibility for benefits. During this time, you will receive your full disability benefits for any month you do not have “substantial” earnings. In 2005, earnings of \$830 per month are considered “substantial”; the amount is \$1,380 if you are blind. You do not need to file a new application for benefits or go through any eligibility review.

3. Quick Restart of Benefits

What if you’ve finished your trial work period, your benefits have been stopped because you’re working enough to bring in “substantial” earnings, but you again find yourself unable to work? In such a situation, Social Security makes it easy to restart your benefits. For five years after your disability benefits stop, you may get an immediate restart of benefits if you again are unable to work, so long as your inability to work is caused by the same disabling condition as before. You need not file a new application for benefits, although you do need to file a simple form requesting the resumption of benefits. Social Security will again review your condition to determine whether you are disabled. However, your benefits should be restarted on the first of the month following your request, without waiting for the review to be completed.

Example: Roberta qualified for Social Security disability benefits because of a congenital back condition that worsened so much in her 30s that

she could no longer work. After several years, however, a new surgical technique was developed that greatly improved Roberta’s condition. Roberta returned to work part time and soon earned a “substantial” income. That meant she no longer qualified for disability benefits. Her back remained strong enough for her to work for two years, but then it began to deteriorate again. Within another six months she found she could no longer work. Because Roberta’s original disability was the same disability that caused her to stop working again within 60 months after she had returned to work, she regained her disability benefits within a month, simply by applying for reinstatement.

4. Continuing Medicare Coverage

If you became eligible for Medicare coverage because you qualified for disability benefits, you do not immediately lose that Medicare coverage once you return to work. When you return to “substantial” work for more than nine months and therefore your disability benefits stop, your Medicare coverage continues for another 93 months. During that time, your Medicare Part A coverage is free; you must pay the same premium for Medicare Part B as other Medicare beneficiaries.





Social Security Dependents Benefits

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A retired or disabled worker with a family obviously needs more money than one living alone—especially given that Social Security benefits currently average only about \$900 per month. The situation is particularly acute when the retired or disabled worker was the family's primary breadwinner. Congress woke up to this reality in 1939, four years after it passed the original Social Security retirement law. It began providing dependents benefits to the spouse and minor children of a retired or disabled worker.

The spouse and children receive these directly, paid as separate checks or deposits.

A. Who Is Eligible

Certain family members of a retired or disabled worker are eligible for monthly dependents benefits if the worker has enough work credits to qualify for, and is claiming, his or her own retirement or disability benefits. The amount of benefits paid to dependents is determined by the worker's earnings record. You don't have to actually depend on the worker for support in order to claim dependents benefits.

I. Individuals Who Qualify

To be entitled to benefits, you need to fit one of the following categories:

- A spouse age 62 or older, with certain conditions (see Section A2, below)
- A spouse under age 62 who is caring for the worker's child who is under age 16 or became disabled before age 22
- Unmarried children under age 18; although benefits to the parents end when the child turns 16, the child continues to receive benefits until age 18
- Unmarried children up to age 19 and still in high school
- Unmarried children of any age if they were severely disabled before they reached age 22, for as long as they remain disabled; for this purpose, disability is defined by Social Security in the same way as for Supplementary Security Income benefits (see Chapter 6)
- Unmarried stepchildren up to age 18 (19 if still in high school) if living with and under the care of the retired or disabled worker
- Grandchildren of the worker, if they live with and are under the actual care of the worker if the parents are deceased or disabled, or if the grandparent has adopted them.

2. Effect of Marriage and Divorce

Couples come in many forms: companions who are not married; couples who are divorced; people who were divorced but have married again. Each status has some ramifications regarding dependents benefits.

a. Divorced Spouses

You are eligible for dependents benefits if both you and your former spouse have reached age 62, your marriage lasted ten years, and you have been divorced two years. This two-year waiting period does not apply if your former spouse was already collecting retirement benefits before the divorce.

You can collect benefits as soon as your former spouse is eligible for retirement benefits at age 62. He or she does not actually have to be collecting those benefits for you to collect your dependents benefits.

Try to Stretch the Marriage to Ten Years

If you are in the process of getting a divorce and you have been married almost ten years, try to have your spouse agree—or stall the legal paperwork long enough—that the divorce will not become final until after ten years.

Under Social Security rules, the marriage is considered in effect until the divorce legally becomes final, even if you and your spouse have already been living apart, you have separated your property, and one of you has begun paying spousal or child support.

If you anticipate that your spouse might object to the delay, you might remind him or her that your dependents benefits have no effect on the amount he or she may collect in retirement benefits. Nor would your benefits affect the amount of dependents benefits a new spouse could collect in addition to yours.

b. Remarried

If you are collecting dependents benefits on your former spouse's work record and then marry someone else, you lose your right to continue those benefits. However, you may be eligible to collect dependents benefits based on your new spouse's work record.

If you divorce again, you can collect benefits again on your first former spouse's record, or on your second spouse's record if you were married for ten years the second time as well.

Whether your former spouse remarries does not affect your eligibility. Nor does your collecting dependents benefits through your former spouse affect his or her new spouse's right to collect benefits. And there is no reduction in either of your benefits because two spouses are collecting them.

c. Unmarried

For the most part, Social Security laws do not recognize the relationship between two adults who are not officially married. There are two exceptions.

First, if one person in a unmarried couple adopts the minor child of the other person, that child becomes eligible for dependents benefits based on the adoptive parent's work record. The other person in the couple does not, however, become eligible for Social Security benefits.

Second, if you live in a state that recognizes common law marriage and you qualify under that state's rules for such marriages, you may also qualify for dependents benefits. The states

that recognize common law marriages are Alabama, Colorado, District of Columbia, Iowa, Kansas, Montana, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Texas, and Utah.

The qualifying rules for a common law marriage vary somewhat from state to state, but all require that you have lived together and have represented yourselves as married by such things as using the same name and owning property together.

Common law marriage does not apply, however, to same-sex couples or to anyone who is still legally married to someone else.

B. Calculating Dependents Benefits

The amount of benefits available to a retired or disabled worker and dependents is calculated based on the total number of people in the immediate family. Social Security figures that the economies of scale permit two to live more cheaply than one, three to live more cheaply than two, and so on. Therefore, the amount by which benefits increase with each additional dependent is smaller and smaller for each person added. (But don't worry, claiming dependents benefits won't reduce the primary worker's retirement benefits.)

I. One Dependent

The amount of your dependents benefits is based on the earnings record of the worker of whom you are a dependent. If there is only one

person claiming dependent benefits, he or she receives an amount equal to 50% of the worker's retirement or disability benefits. If a divorced spouse and the new spouse of a retirement age worker both receive dependents benefits, each will receive 50%.

The best way to find out the amount of retirement or disability benefits that you and your dependents are likely to receive is to request an official Social Security Statement. (See Chapter 1, Sections F and G, for instructions.)



Dependents benefits are also based on what age you claim them at. Like other retirement benefits, a dependent spouse's benefits are permanently lowered if the dependent claims them between age 62 and full retirement age, but permanently increased if not claimed until after full retirement age. (See Chapter 2, Section C, for more on how benefits are calculated.)

At age 65, a dependent spouse is also eligible for Medicare coverage based on the spouse's work record if the spouse is at least age 62. (See Chapter 11 regarding Medicare.)

2. Family Benefits

If your family includes more than one dependent—a spouse and one or more children, or no spouse but two or more children—the benefits paid to the worker and the dependents will be combined into a “family benefit amount.” This amount is less than the total would be if the worker's benefits and individual dependent benefits were paid separately.

The maximum family benefit is 150% to 180% of the retired worker's benefits—the precise amount depends on a complicated Social Security formula—or 150% of a disabled worker's benefits. The retired or disabled worker collects 100% of his or her benefits, and the remaining 50% to 80% is divided equally among the dependents. The actual dollar amount depends on the amount to which the worker is entitled. (See Chapter 2, Sections C and D, for more on benefit calculations.)

Example: Chiang-Fa is retired. Alone, he would be entitled to \$900 per month in retirement benefits. He and his wife Yoka have a 17-year-old daughter. With no daughter, Yoka would be entitled to a \$450-per-month dependents benefit—50% of Chiang-Fa's \$900 retirement benefit.

However, because his daughter is also eligible, the three of them together are limited to a maximum family benefit of 180% of Chiang-Fa's benefit, or \$1,620. That amount would be divided as follows: Chiang-Fa, \$900; Yoka and the daughter, each \$360. Once the daughter reaches age 18, however, she is no longer eligible for dependents benefits, and Yoka would begin to get a full 50% dependents benefit of \$450 per month.

C. Eligibility for More Than One Benefit

Many people are not only eligible for their own Social Security retirement or disability benefits, but also for dependents benefits based on their spouses' work records. As with other Social Security benefits, you are not permitted to double up and collect both.

But do the math before you choose. If your own earnings record is low and your spouse's earnings record high, you may be entitled to higher benefits as a dependent than you would be by collecting your own retirement or disability benefits. You can choose either to wait to claim dependents benefits when your spouse claims retirement or disability, or to claim your own retirement benefits and then switch to higher dependents benefits when your spouse later claims retirement or becomes eligible for disability benefits.

Possible Perils of Claiming Early: Reduced Benefits

If you claim retirement benefits at less than full retirement age, your retirement benefits are reduced by between .5% and .55% per month before full retirement age, depending on the year you were born. (See Chapter 2, Section C, for details.) And if you later switch to dependents benefits, those benefits, too, will be reduced by the same amount as your retirement benefits were reduced.

Example: Clare became eligible for retirement benefits of \$500 per month at age 65. She decided to claim early retirement benefits at age 62—her full retirement amount of \$500 less 20%, for a monthly sum of \$400. When her husband turned 65, he applied for retirement benefits and received \$1,200 per month. Clare switched from her own retirement claim to dependents benefits, which ordinarily would have been \$600, or 50% of her husband's monthly amount. But because Clare had already taken 20% reduced retirement benefits at age 62, her dependents benefits were now reduced by 20%. She ended up getting \$480 per month, instead of the \$600 per month she would have received had she waited.

D. Working While Receiving Benefits

A dependent's benefit will be reduced by \$1 for every \$2 of income earned over the yearly maximum (assuming the dependent is under full retirement age). Once a dependent reaches full retirement age, there is no reduction in benefits, regardless of how much the dependent is earning. (See Chapter 2, Sections B and D, for a full explanation of benefit reductions.)

If several dependents are receiving a combined family benefit amount, one dependent's earnings do not affect the amount the other family members receive.

Example: Grace and Omar and their teenage son receive a combined family retirement and dependents benefit of \$1,650 a month. Grace and the son's portions of the family benefit are \$350 each. Grace is offered a job for a year as a substitute teacher at a salary that is \$6,000 over the yearly earnings limit for her age of 63 years old.

Since Grace's benefit amount is reduced \$1 for every \$2 she earns over the limit, her benefit would be reduced by half (\$1 out of \$2) of \$6,000. That means a reduction of \$3,000, or \$250 per month. Since her own part of the family benefit is \$350, that benefit would be reduced to \$100 per month. The rest of the family's benefits—Omar's \$950 per month and the son's \$350—would not be affected.

E. Public Employee Pension Offset

Millions of people have worked for a branch of government or a public agency—in other words, as federal, state, or local government or civil service employees—and have earned a retirement pension based on that work. (See Chapter 9 for a full discussion of federal retirement pensions.) However, if you receive Social Security dependents benefits as well as a public employment retirement pension (the latter based on your own work record), your dependents benefits will be reduced dollar for dollar by two-thirds the amount of your pension.

There is no offset, however, if you receive a dependents benefit from your spouse's public employment pension. If your spouse is collecting a public pension as well as Social Security, you can collect dependents benefits from both programs without affecting your Social Security benefits.

Not only should you be aware of these rules when figuring out how much your combined government pension and dependents benefits are, but it may affect which pension benefit you choose to collect.

Example: Gina and her husband both worked for the government for many years. Gina is entitled to \$500 per month in Social Security dependents benefits. She is also entitled to both a public employee retirement pension of \$400 per month (her own) and a \$250 per month benefit as a dependent on her husband's public employee retirement pension.

Ordinarily, she would choose to claim her own public retirement pension. But her Social Security dependents benefits would be reduced by two-thirds of her government pension (\$400). If she claims government pension dependents benefits, her Social Security amounts are not reduced at all. She is better off collecting both her smaller public pension dependents benefits (\$250) and her full Social Security dependents benefits (\$500), for a total of \$750 per month, than her larger public pension retirement benefit (\$400) and her reduced Social Security amount (\$500 minus \$333 offset = \$167), for a total of only \$567 a month.



Private employer pensions are not affected.

The pension offset rule does not apply to pensions paid by private, as opposed to government employers. As far as Social Security is concerned, you are entitled to your full Social Security dependents benefits as well as your private pension benefits. However, the rules of a few private pension plans provide that your pension benefits are reduced by what you receive from Social Security.

Exceptions for Those Who Qualified Earlier

The public pension offset rule does not apply if you were eligible for Social Security dependents or survivors benefits before December 1, 1977.

Nor does the rule apply if you began receiving or were eligible to receive a public employment pension before December 1, 1982, and you meet the requirements for dependents benefits in effect in January 1977.

One major rule difference in January 1977 was that a divorced spouse had to have been married 20 years rather than ten years to collect dependents benefits.

The other rule difference reflected a lingering anachronism. For a man to claim dependents benefits back then, he had to prove actual dependence on his wife for at least one-half of his support. There was no such rule for women, however. So, virtually all women who were eligible to receive a public pension before December 1982 could collect both Social Security dependents benefits and their own public pension, while most men could not.



Social Security Survivors Benefits

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The Social Security laws recognize that a worker's family may need financial support after the worker dies. Even if the surviving spouse has always worked, the loss of the deceased spouse's income will almost surely be an economic blow to the family. And if the surviving spouse did not work, or earned much less than the deceased spouse, the loss of the deceased worker's income can be financially devastating. Recognizing the family financial burden brought on by the loss of the primary earner, Social Security provides for what are called survivors benefits to be paid to the spouse and children of an eligible worker who has died.

A. Who Is Eligible

Provided the deceased worker had enough work credits (see Section B, below), here's who can claim survivors benefits:

- A surviving spouse age 60 or over
- A divorced surviving spouse age 60 or over, if the marriage lasted at least ten years
- A surviving spouse under age 60, if he or she is caring for the worker's child who is under age 16 or disabled; this benefit, sometimes called the mother's benefit or father's benefit, may also be paid to a surviving divorced spouse
- A surviving spouse age 50 or over who becomes disabled within seven years of the worker's death or within seven years after mother's benefits or father's benefits end; if

you were divorced, you can collect these disabled survivors benefits only if your marriage lasted at least ten years

- Unmarried children under 18; benefits may continue to age 19, if the child is still a full-time high school student
- Unmarried children of any age who were severely disabled before age 22 and are still disabled
- One or both parents of the worker who are at least age 62 and who were dependent on the worker for at least one-half of their financial support. If an unmarried dependent parent remarries after the worker's death, the parent loses the survivors benefits.

I. Length of Marriage Rule

To collect benefits as a surviving spouse, you must have been married for at least the nine months before the worker's death. However, there are some exceptions to this rule. If you are the biological parent of a child with the worker, or you adopted the worker's child or adopted a child with the worker before the child was 18, the nine-month rule does not apply.

The rule is also waived if you were previously married to the same person and your first marriage lasted more than nine months. And the nine-month rule does not apply if the worker's death was the result of an accident, as opposed to illness, or occurred while he or she was on active military duty.

2. Effect of Remarrying

One of the assumptions behind survivors benefits for spouses is that the majority of surviving spouses are women and that women are financially dependent on their husbands. While things are changing, the fact that there are still fewer women than men in the workforce and women still make only 70 cents to every dollar men earn in wages in comparable jobs means this assumption isn't entirely out of date.

Another reality is that if a surviving spouse—usually a woman—remarries, her need for survivors benefits will end, because there is a new spouse upon whom to depend financially. So a series of qualifying Social Security rules apply to collecting survivors benefits after remarriage:

- A widow or widower who remarries before age 60 loses the right to collect survivors benefits through the deceased spouse, even if he or she still cares for the former spouse's children. The children, however, remain eligible for benefits. (At age 62, the remarried spouse may be eligible for dependents benefits based on the new spouse's record.)
- A widow or widower who remarries after reaching age 60 does not lose survivors benefits from the deceased former spouse. However, he or she may want to transfer—at age 62 or later—to dependents benefits based on the new spouse's earnings record if that benefit would be higher than the survivors benefits.
- If you were divorced from your now-deceased former spouse, and the two of you had been married for at least ten years, you are eligible

for survivors benefits even if you remarried before age 60 but are again widowed or divorced. After age 60, you may remarry without losing your survivors benefits.

Example: Akiko and Yosh were divorced ten years ago, after being married for 25 years. Three years ago, Yosh died. Akiko has a new sweetheart, Ben. They have been together for the past year and are now considering marriage. But Akiko is concerned about the effect their marriage would have on her right to collect Social Security survivors benefits. Akiko is 59, and next year she would be eligible for survivors benefits based on Yosh's work record because their marriage had lasted more than the required ten years.

If Akiko waits one more year, she and Ben can marry and she will still be able to collect survivors benefits based on Yosh's record. If she marries before reaching age 60, she will lose those benefits for good.

B. Whether the Deceased Had Enough Work Credits

Surviving family members of a deceased worker are entitled to survivors benefits only if the worker had earned enough work credits before dying. Work credits are accumulated based on earnings from employment covered by Social Security. The required number of work credits depends on the worker's age at death. (See Chapter 1, Sections C and D, for more on how work credits are earned.)

I. Number of Work Credits Required

The number of work credits on the worker's Social Security record needed for survivors to collect benefits is listed below.

Credits Required From Deceased's Work Record

If the worker was born after 1929 and died or became disabled at age:	If the worker was born before 1930 and died or became disabled before age 62 in:	Work credits needed:
28 or younger		6
30		8
32		10
34		12
36		
38		16
40		
42		20
44		
46	1975	24
48	1977	
50	1979	28
52	1981	
54	1983	32
56	1985	
58	1987	36
60	1989	
62	1991 or later	40

2. Credits Earned Just Before Death

Even if the deceased worker did not have enough work credits according to the chart above, benefits may still be paid to the surviving spouse and children if the worker had at least one and one-half years of work in covered employment in the three years immediately before dying.

C. Amount of Survivors Benefits

Like all other Social Security benefits, the dollar amounts of survivors benefits are determined by the earnings record of the deceased worker. Social Security determines what the full retirement benefit would have been for the worker had he or she not died, then awards a certain percentage of that amount to the survivors.

I. Percentage of Benefits Awarded

Exactly what percentage of the deceased worker's retirement benefit will be awarded to a survivor depends on whether you are the spouse or child of the deceased worker. Also, if you're a surviving spouse, the amount goes up or down depending on the age between 60 and "full benefits age" at which you first claim benefits. "Full benefits age" is set by Social Security based on the year of your birth—it parallels the "full retirement age" set for workers.

As with retirement benefits, the full benefits age will be going up in the coming years. The changes are shown on the following chart.

Full Benefits Age for Widow(er)s

Birth Date	Full Benefits Age
1/1/40 or earlier	65 years
1/2/40-1/1/41	65 + 2 months
1/2/41-1/1/42	65 + 4 months
1/2/42-1/1/43	65 + 6 months
1/2/43-1/1/44	65 + 8 months
1/2/44-1/1/45	65 + 10 months
1/2/45-1/1/57	66
1/2/57-1/1/58	66 + 2 months
1/2/58-1/1/59	66 + 4 months
1/2/59-1/1/60	66 + 6 months
1/2/60-1/1/61	66 + 8 months
1/2/61-1/1/62	66 + 10 months
1/2/62 and later	67

a. Surviving Spouse at Full Benefits Age

A surviving spouse who waits until the age at which he or she becomes eligible for full benefits to claim benefits will receive 100% of what the deceased worker's full retirement benefit would have been.

As with retirement benefits, the age at which a person may collect full survivors benefits is currently 65—but this will change for some people. For people born in 1940 or after, the

survivors full benefits age will gradually rise, finally reaching age 67 for those who were born in 1962 or after.

b. Surviving Spouse Under Full Benefits Age

A surviving spouse at age 60 will receive 71.5% of what the worker's full retirement benefits would have been. Each year a surviving spouse delays claiming benefits after age 60, those benefits will rise 4.1% to 5.7% per year, depending on the year of birth, until the survivor reaches full benefits age. (See chart above.)

Delaying benefits may be a good idea for survivors who are under full retirement age and who are still working. (See Section E, below, for more on working while receiving benefits.)

c. Surviving Spouse Caring for Child

A surviving spouse who is caring for the worker's child, if that child is younger than 16 or disabled, is eligible for benefits regardless of the surviving spouse's age. The amount of benefits will be 75% of what the worker's full retirement benefits would have been.

d. Minor or Disabled Child

A surviving minor or disabled child receives 75% of what the worker's retirement benefits would have been. This is over and above what the parent receives, as described in Section C, above. However, there is a per-family maximum, discussed in Subsection f, below.

e. Dependent Parent

A surviving parent who was dependent on his or her deceased son or daughter for at least half of his or her financial support may be eligible for 75% of what the deceased worker's retirement benefit would have been. For both surviving dependent parents, the total is 82.5%.

f. Surviving Spouse and Children Together

A surviving spouse and children together are not entitled to the full amount each would get alone. A maximum is placed on the total amount that one family can receive.

The family benefit limit is 150% to 180% of what the deceased worker's retirement benefits would have been. The benefits are divided equally among the surviving spouse and children.

2. Estimating Benefit Amounts

You can get a general idea of survivors benefit amounts by looking at these recent average figures.

a. Low Income

The survivor of a worker who had relatively low income most of his or her working life—\$10,000 to \$20,000 per year in current dollars—will receive monthly benefits of between

\$500 and \$800. If both a surviving spouse and a minor child will be receiving benefits, the total for the two would be between about \$800 and \$1,200.

b. Moderate Income

The survivor of a person who had a moderate annual income—\$20,000 to \$30,000 in current terms—will receive between \$800 and \$1,400 per month. A surviving spouse and child would receive a total of between about \$1,500 and \$2,000.

c. High Income

The survivor of a worker who averaged relatively high earnings—\$40,000 per year or more in current dollars—can expect between \$1,400 to \$1,800 per month. The high earner's surviving spouse and child together would receive between \$1,600 and \$2,400.

d. Getting an Official Estimate

While a worker is alive, he or she can get a very accurate personal estimate of what his family members' survivors benefits are likely to be, directly from Social Security. The worker can, at any time, request a Social Security Statement and receive the figures within two to six weeks. (See Chapter 1, Sections F and G, for instructions.)

D. Eligibility for More Than One Benefit

Many surviving spouses are eligible for their own Social Security retirement or disability benefits, and also for benefits based on their spouses' work records. However, you are permitted to collect only one type of benefit. If your own earnings record is low and your deceased spouse's earnings record was high, you may be entitled to higher benefits as a surviving spouse than as a retired or disabled worker.

Even if you will ultimately be eligible for a higher retirement benefit after you turn age 62, you can claim survivors benefits as soon as you are eligible at age 60, and then switch to your own retirement benefits whenever they become higher than your survivors benefits. Claiming survivors benefits before you reach full retirement age does not reduce your own retirement benefit.

It also works in reverse: You can claim reduced early retirement benefits—between age 62 and full retirement age—on your own work record, and then switch to full survivors benefits at any later age if those benefits would be higher.

Example: Francesca would be eligible for full retirement benefits of \$600 per month at age 65, based on her own work record; at age 62, she is eligible for reduced retirement benefits of \$480 per month. At age 65, she would also be eligible for a full survivors benefit of \$800 per month based on her deceased husband's work record; at age 62, she is eligible for a reduced survivors benefit of \$660 per month.

Francesca has two choices at age 62: She can claim her early retirement amount of \$480 per month and then switch to full survivors benefits of

\$800 per month at age 65. Or she can claim her reduced survivors benefits of \$660 per month at age 62 and collect that amount, plus cost-of-living increases, for the rest of her life. She could switch to full retirement benefits at age 65, but in her case they would be only \$600 per month, less than her reduced survivors benefits.

Francesca has to decide whether she can get along well enough with the \$480-per-month retirement benefits she would receive for three years until she switched to her \$800 survivors benefits. If she can manage, then waiting would be better in the long run. Waiting makes particularly good sense if she will also be working during those three years, because her benefits might be reduced because of her earnings.

One-Time Payment for Funeral or Burial Expenses

In addition to the monthly survivors benefits to which family members may be entitled, a family may also receive a one-time-only payment—currently \$255—intended to defray funeral or burial expenses. A surviving spouse can claim the money if the couple was not divorced or legally separated at the time of death.

A divorced widow or widower can still collect the \$255 if he or she qualifies for the regular survivors benefits. And if there is no qualifying spouse, the sum may be paid to the surviving minor children, divided equally among them. You must file a claim for the death benefit at your local Social Security office within two years of the worker's death.

E. Working While Receiving Benefits

Many surviving spouses find that despite their survivors benefits, they also have to work to make ends meet. How much a surviving spouse earns, however, can affect the amount of benefits he or she receives.

The benefit for a surviving spouse who is less than full retirement age will be reduced by \$1 for every \$2 of income earned over the yearly maximum. Once a surviving spouse reaches full retirement age, there is no reduction in benefits, regardless of how much is earned. (See Chapter 2, Section D, for details.)

If a widow or widower and children are receiving a combined family benefit amount, the parent's earnings do not affect the amount the children receive.

Example: Manjusha and her teenage son receive a combined family survivors benefit of \$1,500 a month, or \$750 each. Manjusha is taking a job at a salary that is \$6,000 over the yearly earnings limit.

Since Manjusha is 62, her benefit amount is reduced \$1 for every \$2 she earns over the limit. Her benefits would be reduced by half of \$6,000, for a total reduction of \$3,000, or \$250 per month. Since her own part of the family benefit is \$750, that benefit would be reduced to \$500 per month. Her son's \$750 would not be affected.

F. Offset for Public Employment Pension

If you worked enough years for a local, state, or federal government agency, you may be entitled to a civil service retirement pension. However, if you are also entitled to a Social Security survivors benefit based on your deceased spouse's work record, collecting that pension may cause you to lose a portion of that survivors benefit.

Your survivors benefits will be reduced dollar for dollar by two-thirds of the amount of your pension. There is no such offset, however, if the public pension you receive is as a surviving spouse (in other words, if your husband or wife was a public employee) rather than as a retiree on your own work record. You can collect survivors benefits from both programs without affecting your Social Security benefits.

This rule will not only affect how much your combined government pension and dependents benefits are, but it may also cause you to choose to collect your own Social Security retirement benefits, if you are eligible for them, rather than Social Security survivors benefits. The combination of your public employment retirement pension and your own Social Security retirement benefits may total a higher amount than your survivors benefits reduced by two-thirds the amount of your pension.

Example: Alice is entitled to \$500 per month in Social Security survivors benefits based on her deceased husband's nongovernment work record. She is also entitled to both a public employee retirement pension of \$400 per month and a \$250 per month benefit as a widow based on her husband's public employee retirement record. Ordinarily, she would choose to claim her own

public retirement pension rather than the lower public employee widow's benefit.

But her Social Security survivors benefits would be reduced by two-thirds of her government pension (\$400); while if she claims government pension dependents benefits, her Social Security amounts will not be reduced at all. She is better off collecting both her smaller public pension dependents benefits (\$250) and her full Social Security dependents benefits (\$500) rather than her larger public pension retirement benefit (\$400) and the reduced Social Security amount which would result (\$500 minus \$267 offset = \$233).

The pension offset rule does not apply to pensions paid by private, nongovernmental employers. However, the rules of a few private pension plans provide that your pension benefits will be reduced by what you receive from Social Security.

Also, the public pension offset rule does not apply if you were eligible for Social Security survivors benefits before December 1, 1977, or you were eligible to receive a public employment pension before December 1, 1982, and you meet the pre-1977 rules, which required that a divorced spouse had been married 20 years, rather than ten, to collect survivors benefits.





Supplemental Security Income

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Over five million people receive some Supplemental Security Income, or SSI, benefits. SSI is a program jointly operated by the federal and state governments and administered by the Social Security Administration. SSI is intended to guarantee a minimum level of income to financially hard-pressed older, blind, and disabled people.

SSI eligibility is based entirely on your age or disability, and on financial need as determined by both your income and your assets. SSI benefits do not depend on how long you have worked, or on how much you have paid into the Social Security system.

You must be quite financially needy to qualify for SSI payments. Indeed, your income and assets must be so low that many people with no income other than their Social Security retirement benefits are not eligible for SSI. Others receive only a small SSI supplement to their Social Security benefits.

Nevertheless, if after reviewing the rules explained in this chapter you think you may be close to meeting the requirements for SSI eligibility, it will be worth your while to apply for it. If you qualify for SSI, you may also be eligible for Medicaid (discussed in Chapter 15) and food stamps, as well as free rehabilitation and home care programs, should you need them.

A. Who Is Eligible

You must meet four basic requirements to be eligible for SSI cash benefits:

- You must be 65 or over, or blind or disabled.
- If you're a new applicant for SSI benefits, you must be a citizen of the United States, or meet strict requirements for longtime residency, military service, or political asylee or refugee status.

Some legal permanent residents of the United States may also be eligible for SSI benefits if they are blind or disabled.

- Your monthly income must be less than a certain minimum amount established by the state in which you live.
- Your assets must be worth less than \$2,000, or \$3,000 for a couple, although certain items are excepted from this amount, including your car and home.



The rules for each of these requirements are more complicated than they first appear.

But the complications almost always make it easier for you to qualify for SSI benefits than you might first imagine. Generally speaking, you are permitted to have more income and assets than the initial figures indicate.

I. Blind or Disabled

If you are under age 65, you can qualify for SSI payments if you are blind or disabled.

Basically, you are considered blind if your vision is no better than 20/200, or your field of vision is limited to 20 degrees or less, even with corrective lenses.

You are considered disabled if you have a physical or mental impairment that prevents you from doing any substantial work and that is expected to last at least 12 months, or to result in death. This definition of disabled is similar to the test used for Social Security disability benefits. (This test is discussed in Chapter 3, Section B.) But unlike the Social Security disability program, which looks only at the income you currently earn, SSI looks at income from all sources, and measures that income in a more complicated way.

2. Citizens or Longtime Residents

SSI benefits are generally available only to U.S. citizens and longtime legal residents. Noncitizens must fall within one of the narrow categories described below.

The restrictions hit some of the country's neediest people the hardest. These are people, often elderly, who have lawfully immigrated to this country to join their children or siblings, only to be met here by joblessness and poverty.

As a noncitizen of the United States, you qualify for federal SSI benefits only if:

- you have a legal right to live in the U.S. and you were already receiving SSI benefits on August 22, 1996, or
- you were legally living in the United States on August 22, 1996, and you are now blind or disabled, or
- you are a lawful permanent resident of the United States (a green card holder) and you or your spouse have worked for at least ten years in this country, having paid at least the minimum Social Security taxes to qualify for 40 quarters of work credits (see Chapter 1, Section D), or
- you are a veteran (honorably discharged) or active duty member of the U.S. Armed Forces, or the spouse or child of one, or
- you have been granted political asylum or refugee status; however, your benefits in this situation will last for only seven years after you have been admitted to the country.



For a more detailed discussion of immigrants' eligibility for SSI: See the National Immigration Law Center website at www.nilc.org or contact their Los Angeles office at 213-639-3900.

State Benefits May Be Available

Nondisabled noncitizens who were in the United States but not receiving SSI benefits as of August 22, 1996 are generally not eligible for federal SSI benefits. However, if you fall into this category but you have now reached age 65, your state might provide you with SSI benefits, as well as food stamps. You may also be eligible if you arrived in the United States after August 22, 1996 but your immigration sponsor has since died or become disabled. If you are in one of these categories, apply for both federal and state SSI assistance; you may be entitled to state benefits even if you are denied federal SSI.

3. Income Limits

To figure out whether your income is low enough to qualify for SSI, you first need to understand that there are actually two SSI payments:

- the basic federal SSI payment, and
- a supplemental SSI payment, which some states pay over and above the federal benefit, and which other states pay alone if you qualify for it, even if you do not qualify for the federal payment.

Not all your income is counted when deciding whether you qualify for SSI. In fact, more than half of your earned income—wages and self-employment income—is not counted. And even though you may have income over the allowable maximum for federal SSI payments, you might still qualify for your state's supplemental payment. A few states set a higher in-

come limit than the federal SSI program does, making it easier to qualify for those states' supplemental payment than for the federal one. (See Section B, below.)

The federal SSI limit on counted income is about \$500 to \$700 per month for an individual, or \$750 per month for a couple. The exact figure varies from state to state. In many states, however, you would qualify for the state's SSI supplemental payment—as well as Medicaid, food stamps, and other assistance—even if your counted income was too high to qualify for federal SSI. (See Sections B1 and B2, below, for more on state supplements.)

a. Income That Is Counted

In general, any income you earn in wages or self-employment and any money you receive from investments, pensions, annuities, royalties, gifts, rents, or interest on savings is counted toward the SSI limits. Social Security benefits are also considered counted income. In addition, if you receive free housing from friends or relatives, the value of that housing—based on what similar housing would cost in your area if you had to pay for it—may be considered as counted income by SSI. In other states, such arrangements are not considered as income, but result in you receiving a lower SSI benefit. (See Section C3, below, regarding these limits on outside support.)

b. Income That Is Not Counted

Some specific amounts of money and support are not counted in determining whether you need SSI benefits.

SSI will not count:

- the first \$20 per month you receive from any source—except other public assistance based on need, such as General Assistance
- the first \$65 per month of your earned income—wages or self-employment
- one-half of all your earned income over \$65 a month
- irregular or infrequent earned income—such as from a one-time-only job—if such income is not more than \$10 a month
- irregular or infrequent unearned income—such as a gift or dividend on an investment—up to \$20 per month
- food stamps, energy assistance, or housing assistance from a federal housing program run by a state or local government agency
- some work-related expenses for blind or disabled people that are paid for through public assistance, or
- some other types of one-time payments, such as tax refunds, reimbursement for financial losses such as insurance payments for medical bills, or compensation for injury to you or your property.

c. Differences in Local Rules

Keeping in mind that different income limits apply in various states, one general suggestion applies to everyone: If you are age 65, blind, or disabled; you are living on a small fixed income; and you have relatively few assets (discussed in Section A4, below), apply for SSI benefits. The local Social Security or social welfare office may consider certain income differently than you do, and you may be pleasantly surprised to gain some help from SSI.

Example: Carmela receives Social Security survivors benefits of \$310 a month and a \$40-per-month private pension payment, for a total of \$350 in regular unearned income. She also receives a quarterly dividend check; the most recent was \$15.

The dividend check would not be counted at all, because it is infrequent income less than \$20. The first \$20 of income from any source is not counted, so the \$350 total of unearned income would be reduced to \$330 of countable income.

Carmela also earns \$210 a month doing part-time work. Since the first \$65 a month of earned income is not counted, her earned income amount would be reduced to \$145; and since one-half of all earned income over \$65 a month is not counted, half of \$80 (\$145 minus \$65) would not be considered for SSI purposes.

This leaves Carmela with \$105 countable earned income to be added to the \$330 countable unearned income for the month, for a total of \$435 countable income. Since this amount is under the basic SSI qualifying limit of about \$500 per month, Carmela would be eligible for the basic federal SSI payment. Because Carmela lives in New York where there is a state supplemental benefit, she may be eligible for that amount as well. (See Section B1, below.)

4. Asset Limits

In addition to the limits on your income, SSI rules limit the amount of assets and other resources you may have and still qualify. The general limit is \$2,000 in assets for an individual, \$3,000 for a married couple living together. But as with the rules regarding income, people are actually allowed more assets than these figures seem to indicate.

a. Assets That Are Counted

The assets or resources that are counted by SSI include money in the bank, investments of any kind, real estate other than a primary residence, and personal property and household goods over certain limits. (See Subsection b, below, for more on the exceptions and limits.)

They also include any money or property in which you have an interest, even if you are not the sole owner. If you have a joint bank account with someone, or hold any property in joint tenancy with someone else, SSI will consider that you own the entire account or property, because you have access to all of it. If you have only a partial interest in some property—for example, an ownership interest in a family home along with other family members—SSI will determine how much your individual ownership portion is worth and count that as an asset.

b. Assets That Are Not Counted

You are allowed to have more property of value than the \$2,000 and \$3,000 limits first indicate. Several important categories of assets are not counted in determining your eligibility for SSI benefits. They include:

- your home and the land it sits on, regardless of value, as long as you live in it
- your automobile, up to a current market value of \$4,500; and if your car is used in your work, or is for getting to and from a job or regular medical treatment, or is specially equipped for the transportation of a handicapped person, the value of your car is not counted no matter how much it is worth

- your personal property and household goods—such as clothing, furniture, appliances, tools, sporting goods, and hobby or craft material—up to a total current value of \$2,000; the value is not judged by what the articles cost new, but by what you could sell them for now, less the amounts you still owe on them
- wedding and engagement rings, regardless of value
- property needed for medical reasons, such as wheelchairs, hospital beds, prosthetics
- property essential to self-support—such as tools and machines used in your trade—up to a value of \$6,000.
- life insurance policies with a total face value of \$1,500 or less per person, and term life insurance policies with no cash surrender value, and
- burial spaces for you and your spouse, plus a specially earmarked fund of up to \$1,500 for funeral and burial expenses.

Example: Rose and Peter are living on Peter's Social Security retirement benefits and on Rose's pension. They qualify under SSI income limits, and have the following assets: their home; a five-year-old car; \$1,500 in savings; stocks worth \$500; kitchen appliances worth about \$300; a TV worth about \$100; a stereo worth perhaps \$150; Peter's carpentry tools, worth about \$500; and Rose's jewelry which, aside from her wedding band, is worth about \$200.

Despite the fact Rose and Peter's house is now worth \$120,000, it is not counted as an asset. Their car is not worth \$4,500, so it is not counted at all. Their personal property and household goods add up to about \$1,350, but none of it will be counted because this is below the permissible amounts for personal property.

Their total counted assets would be their savings and stocks worth about \$2,000. Since the SSI limit on resources is \$3,000 for a couple, Rose and Peter would qualify for SSI benefits.

c. Selling or Spending Assets

Even if your countable assets appear to be over the limits, it may still be possible for you to qualify to receive some SSI benefits. You may begin to receive SSI payments if you sell or spend enough property to come under the limits within a certain time period. That time period begins when you apply for benefits and runs six months for real estate and three months for personal property and liquid assets.

However, the sale or transfer must be a real one. Simply transferring title on the property to someone else while you keep control or use of it is not enough; neither is selling something for a token sum.

Example: Mariana applies for SSI benefits when she has more than \$5,000 in the bank. She is told that she will not be immediately eligible for benefits unless that amount is reduced to \$2,000 within the next three months. Mariana had always planned to be buried near her deceased husband, but never got around to making the arrangements. She now buys a burial space for \$2,000 in the same cemetery as her husband. Then she puts \$1,000 in a special account to cover her funeral expenses. Since funeral and burial amounts are not counted as assets under SSI rules, and her assets are now down to \$2,000 (within three months of her application for SSI), she will begin receiving benefits as of the date she applied.

B. Benefit Amounts

Because supplementary payments vary from state to state, the amount of your SSI check will vary depending on where you live, as well as on the amount of your countable income. The basic federal SSI payment for 2005 is \$579 a month for an individual, \$869 a month for a couple. These figures go up on January 1 each year; the amount of increase depends on the rise in the federal Consumer Price Index.

I. States With Federally Administered Supplements

A number of states pay supplements to the basic federal SSI amount. In these states, the supplement is added on directly to the federal SSI payment. This means that a person needs to apply only once, to Social Security, to receive both the basic amount and the supplement. Both amounts are included in one payment, which is administered by Social Security.

The amount of the supplement differs for a single individual, a couple, or a person who is blind. Also, the amount may be affected if the person receiving SSI lives in the home of a family friend, in congregate living arrangements, or in a nursing facility.

States in which SSI recipients receive a federally administered supplement include:

California	New Jersey
District of Columbia	New York
Hawaii	Pennsylvania
Massachusetts	Rhode Island
Nevada	Vermont

Note that Delaware and Montana have federally administered supplements that are available only to people who live in protective care arrangements.

2. States With Their Own Supplements

Most other states provide some kind of supplement to the basic federal SSI payment, but the kinds of supplements and rules for qualifying are administered entirely by the states. You must apply for these state supplements separately, at the social welfare agency in the county where you live.

Your supplement payments might range from a few dollars to a few hundred dollars above the basic federal SSI payment, or include noncash assistance with food, housing, transportation, and/or medical care. The amounts change frequently, based on the willingness of state legislatures to provide for SSI recipients in their state budgets.

SSI May Get You Medicaid

If you are found eligible for SSI benefits, most states will also give you free health coverage through the Medicaid program (called Medi-Cal in California). You don't need to qualify for Medicare to get Medicaid. For an explanation of what Medicaid offers, see Chapter 15.

Your enrollment is automatic in many states, including Alabama, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.

In other states, you must separately apply for Medicaid after being granted SSI. This usually involves submitting an application to a state social services or welfare office. Some states will automatically enroll you based on your SSI grant. Others have slightly more restrictive eligibility standards and will separately evaluate your Medicaid application.

The states that automatically enroll you after you apply for Medicaid are Alaska, Kansas, Idaho, Nebraska, Nevada, Oregon, and Utah. The states that make an independent decision about whether you are eligible for Medicaid are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.

C. Reductions to Benefits

Your maximum benefit amount will be reduced by any income you make over allowable countable limits, as dictated by a number of specific rules.

1. Limit on Earned Income

Your benefits are reduced by one dollar for every two dollars more than \$65 per month you earn in wages or self-employment.

Example: Ronda has a part-time job at which she earns \$280 a month. She is entitled to the basic federal SSI benefit of \$564 per month, but that amount is reduced by \$107.50 because of her earnings. (The total of \$107.50 is arrived at by taking the amount of her earned income over \$65 (\$215) and dividing it in half—one out of every two dollars over the limit.) Her monthly income would then be her earnings of \$280 plus her SSI benefit of \$456.50, for a total of \$736.50.

2. Limit on Unearned Income

Your benefits are reduced dollar for dollar by the amount of any unearned income you receive over \$20 a month. This unearned income includes your Social Security benefits, pensions, annuities, interest on savings, dividends, or any money from investments or property you own.

Example: Carl lives alone in a home he owns. His only income is his Social Security retirement check of \$330 per month. From Carl's \$330 Social Security check, \$20 is excluded, making his

total countable unearned income \$310. Since he has no earned income, his total countable income would be the same: \$310. In the state in which Carl lives, the basic SSI payment is \$600 per month. From this, Carl's total countable income of \$310 is subtracted, leaving \$290 as Carl's monthly SSI payment.

3. Limit on Outside Support

Your basic SSI payment will be reduced by one-third if you live in a friend's or relative's home and receive support in the form of food or clothing from them.

Example: Adam lives in his daughter and son-in-law's house. His only income is his monthly Social Security retirement check of \$270. His daughter and son-in-law provide food for Adam, as well as give him a place to live. The basic SSI benefit of \$598 in Adam's state would be reduced by one-third because Adam receives food and lodging from his daughter and son-in-law. This would leave an SSI amount of \$399. Adam's only income is his Social Security check of \$270; \$20 of that amount is not counted, leaving a total countable income of \$250. This \$250 is subtracted from his SSI amount, leaving a monthly SSI payment to Adam of \$149, in addition to his Social Security check.

4. Limits on Working Couples

A final example shows how SSI amounts are figured for a couple, and how SSI payments change when one person takes a job.

Example: Beverly marries Carl and together they collect a monthly Social Security check of \$455. In figuring Carl and Beverly's SSI payment, \$20 would be exempted from the \$455 Social Security check, for a total countable income of \$435 a month. That \$435 would be subtracted from the basic SSI benefit for a couple, which in Carl and Beverly's state is \$937, leaving a monthly SSI payment of \$502.

When Beverly takes a part-time job paying \$100 a month, their SSI payment changes. Beverly and Carl's countable unearned income is still the same \$435 a month—their Social Security check minus \$20. But now they have an earned income of \$100 a month. The first \$65 of

this \$100 is not counted under SSI rules. Of the remaining \$35 of earned income, only one-half of it, or \$17.50, is considered counted income. Only \$17.50 is added to the \$435 of counted unearned income, making a total countable income of \$452.50 a month.

The basic SSI benefit for a couple in Carl and Beverly's state is \$937 a month. The \$452.50 countable income would be subtracted from this amount, leaving a monthly SSI payment to Carl and Beverly of \$484.50. Their monthly income would be their Social Security check of \$455, plus their part-time income of \$100, plus their SSI check of \$484.50, for a total of \$1,039.50.





Applying for Benefits

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Once you get an accurate estimate of how much your Social Security benefits will be and decide when it is best to begin receiving them, applying for those benefits is usually fairly simple. Most people will already have all the documents needed, and can complete their application in one or two trips to a local Social Security office. This chapter explains the process:

- Section A explains the basics of applying for the main Social Security benefits: retirement benefits (discussed in Chapter 2), dependents benefits (discussed in Chapter 4), and survivors benefits (discussed in Chapter 5).
- Section B explains the application for disability benefits (discussed in Chapter 3), which has several steps. This is a more complicated procedure than for other Social Security benefits and requires the greatest preparation. Section B explains the important role your doctor can play and will prepare you for the many steps you must take to qualify for benefits.
- Section C explains how to organize the required documents relating to your income and assets. (See Chapter 6.)

A. Retirement, Dependents, and Survivors Benefits

The application processes for retirement benefits, dependents benefits, and survivors benefits all involve the same basic documents and procedures. The hardest part is figuring out the best

time to claim benefits. For this, you must understand the relationship between your age and the amount you will receive.

I. When to Claim Benefits

You may be eligible for different types of benefits at different times in your life—for example, survivors benefits at age 60, based on your deceased spouse's work record, and retirement benefits at age 62, based on your own work record. And you are eligible for increased benefits for every month you wait to claim them up to age 70.

As a result, your decision about which benefits to claim and when to claim them should be based on how much each benefit would be, measured against the earnings limit for your age, if you intend to continue working. (For earnings limits and reductions, see Chapter 2, Section D; for reductions for working dependents, see Chapter 4, Section D; and for reductions for working survivors, see Chapter 5, Section E.)

To find out what each type of benefit would be at different ages, request a copy of your Social Security Statement. (See Chapter 1, Sections F and G, for instructions.) You should request this about six months before you would become eligible for a particular benefit; it takes several weeks for Social Security to get it to you. This will give you plenty of time to decide what's best, and to get the process started if you choose to file immediately.

2. How and Where to File Your Claim

All Social Security claims for benefits can be filed at local Social Security offices. In addition, retirement and dependents benefits may be initiated by phone or through the Internet (see “Begin Your Application Process Online,” below.) Even online applications usually require a visit to a local office to complete, however.

Most sizable cities have at least one local Social Security office, and in major urban areas there are usually several. To find the address and telephone number of the nearest office, check your telephone directory under the listing for U.S. government, Social Security Administration, or sometimes under U.S. Government, Department of Health and Human Services, Social Security Administration. The SSA website also has listings of local offices, at www.ssa.gov. Look for the link “Find your nearest Social Security office.” If you’re still having trouble finding a local office, call the SSA at 800-772-1213.

The following subsections describe how to get personal assistance with and local information about how to file your claim.

a. Help in Person

A Social Security worker in your local office is usually the best source of information and assistance for filing your claim. Face-to-face conversation is almost always more productive than discussions over the phone or via email messaging. And when you’re ready to file your application, handing it to a real person is more secure than sending it by mail.

Most offices permit you to phone in advance and make an appointment to speak to someone personally—a good idea, since you may face long lines if you show up unannounced.

Whenever you consult with someone in a Social Security office, write down the person’s name and keep it with your other Social Security papers. That way, when you next contact the office, you can ask to speak with the same person, or you can refer to that person if a question arises about what occurred during your previous visit.

When filing papers, make sure the office gives you some proof that you filed—for example, bring along your personal copy and ask them to stamp it “received” with the date, as they would for their daily mail.

b. Help Over the Telephone

Social Security offers advice and help over its toll-free phone line at 800-772-1213. The phone lines are open between 7 a.m. and 12 p.m. Eastern time Monday through Friday. It’s busiest at the beginning of the month and early in each week, so choose your time to call accordingly.

You can accomplish a great deal over the phone. The Social Security workers can answer your general questions about benefits and rules and tell you how to fill out or submit a particular form. They may also be able to start your claim process for retirement and dependents benefits. However, that process cannot be completed over the phone. Before your claim can actually be processed, you’ll have to sign a written application and bring it to Social Security with certain original documents (described in Section 3, below).

c. Help on the Internet

Social Security now offers a good deal of information on the Internet, at www.ssa.gov. Unfortunately the information is sometimes poorly organized. How much you'll use it probably depends on how comfortable you are perusing multilayered websites.

One convenience you might take advantage of is to begin your application for retirement or dependents benefits online, as described below.

Begin Your Application Process Online



The Social Security Administration encourages workers and their spouses to use the Internet to file claims for retirement and/or dependents benefits. (See Chapters 2 and 4.) Unfortunately, the reality hasn't quite caught up with the promises. Anyone who is at least 61 years and nine months old may fill out an application online, at www.ssa.gov/applytoretire. The online application is sent to Social Security electronically, where it receives a "claim control number."

However, the claim cannot be processed until you give the SSA, in person or by mail, a signed hard copy of the application and its accompanying original documents. Most people prefer to set up an appointment to submit this in person. If you submit your materials by mail, the SSA usually processes your claim and responds within two to four weeks.

The one advantage to filling out the application form online appears to be that it jump-starts the process—leading to a quicker result than merely filing everything in hard copy.

Sign Up Three Months Before Your Birthday

If you will need to actually receive a benefit payment as soon as you reach the youngest eligibility age, file your claim three months before the birthday on which you will become eligible. This will give Social Security time to process your claim so that you will receive benefits as soon as you become eligible. If you file a claim later, you cannot get benefits retroactively for months during which you were eligible but before you applied.

Anyone eligible for Social Security benefits is also eligible for Medicare coverage at age 65 (explained in Chapter 12). Even if you are not going to claim Social Security benefits at age 65—because your benefit amount will be higher if you wait—you should sign up for Medicare coverage three months before your 65th birthday. There is no reason to delay signing up for Medicare, and waiting until after your 65th birthday will delay coverage.

Getting the Best Results: Preparation, Patience, Perseverance

Social Security offices are usually understaffed. Although individual Social Security workers are often helpful, polite, and well-versed in the various regulations that govern Social Security programs, the maze of rules, when added to normal human fallibility, inevitably makes for delays, misunderstandings, and mistakes.

It's up to you to help yourself. The best way to begin the Social Security application process is to use this book to understand the workings of whichever benefit program you will apply for.

The next most important thing is to keep your papers organized. During the benefit application process, you may mail papers and forms to your local Social Security office. However, it is best to deliver important papers—any original document or certified copy—in person. That way, the papers not only will be sure to get to the local office but also will go directly into your file. This will cut some time off the process and will help to avoid the adventures that sometimes befall papers that go into Social Security's incoming mail stacks.

Keep copies of any form or document you submit to Social Security. If the local Social Security office asks to see the original or a certified copy, it will usually make a copy on the spot and return the original to you. It's best to keep a copy in your files in case the original gets lost.

3. Documents You'll Need

The waiting time for service in most local Social Security offices is longer than one would like. Some people suggest the most important things to take with you to Social Security are a sandwich and a book. But personal needs aside, when you visit a Social Security office to apply for benefits, bring with you all the papers that relate to your claim; that will speed up the process and may save you an extra trip.

Most documents required by Social Security must be originals or certified copies. However, if you want to apply for benefits right away but do not yet have all your documents together, file your claim anyway—either by phone, on the Internet, or by going to your local Social Security office. The Social Security workers will advise you about how to get the documents you need, and, in the meantime, the application process can begin.



Make sure all your papers can be traced to you. On any copy of a document you bring or send to Social Security, write your name as it appears on your benefit application and your Social Security number. Also include the name and Social Security number of the person on whose work record you are claiming benefits. If you bring or send an original document, clip a piece of paper to it with those names and numbers.

When you apply for any type of benefit, bring with you the number of your account at a bank, credit union, or other financial institution. Social Security will arrange to have your monthly benefit payment sent directly to your account—a process called direct deposit. Direct deposit is now used for all new Social Security and SSI beneficiaries. It saves money for the Social Security Administration and also avoids the problem of lost or stolen checks.

a. Retirement Benefits

Bring the following documents with you when you apply for retirement benefits:

- Your Social Security number. You do not need your actual Social Security card.
- Your birth certificate. If you do not have a birth certificate, bring any other evidence of the date of your birth: baptism record, military papers, immigration papers, driver's license, passport.
- Your military discharge papers, if you served in the military.
- Your most recent W-2 tax form or federal self-employment tax return.

b. Dependents Benefits

Bring the following documents with you when you apply for dependents benefits:

- Marriage certificate, if you are applying for benefits based on your spouse's work record.
- Birth certificate of any children claiming benefits. If you do not have a birth certificate, bring any other evidence of the date of your

child's birth: baptism record, immigration papers, passport.

c. Survivors Benefits

Bring the following documents with you when you apply for survivors benefits:

- Social Security number of the deceased person on whose work record you are claiming benefits, and your own Social Security number.
- Divorce papers, if you are applying as a divorced spouse.
- Death certificate of your deceased spouse.
- Your birth certificate and those of your children who are claiming benefits. If a birth certificate is not available, bring any other evidence of date of birth: baptism record, military papers, immigration papers, passport.
- If your spouse died within the past two years, the most recent W-2 tax form or federal self-employment tax return of your deceased spouse.
- If applying as a surviving dependent parent who was receiving support from your son or daughter who died, bring a recent tax return from your deceased child showing you as a dependent, or proof of expenditures by your deceased child showing how much support was given to you, as well as your own most recent tax returns.

If You Retire From Your Own Business

If you are self-employed and are claiming retirement benefits before your full retirement age, Social Security may require some extra information from you. They'll want to see evidence that you are really giving up full-time work and not merely shifting your pay, (in name only), to someone else.

The reason for this concern is the rule that retirement benefits will be reduced if you are less than full retirement age and earn income over certain limits for your age. (See Chapter 2, Section D, for these limits.) Some people with their own businesses try to get around this rule by continuing to work and paying a relative instead of themselves, or by continuing to run the business but being paid only for reduced work time.

Social Security is likely to ask for information regarding your continuing involvement with your own business if:

- you maintain ownership of the business
- other family members are involved in the business and a relative is assuming most of your previous duties
- you continue to work for the business at lower pay
- you control the amount you work and how much you are paid, such that you could manipulate either one
- your relatives now receive the salary you previously earned.

Social Security may ask for such documents as the business's pay and personnel records, personal and business tax returns, stock transfer agreements, and business expense records. Try to contact your local Social Security office several months in advance, so

that you'll learn what documents Social Security wants and have time to gather the documents.

If Social Security determines that you provide services to the business that exceed the amount you are paid—based on the time you spend, the level of your responsibility, and the value of services you provide—the agency may attach a dollar value to those services. If this dollar value exceeds the amount of earned income permitted for your age, your benefits may be reduced.

4. At the Social Security Office

When submitting your application at your local Social Security office, you will be interviewed by a case worker. If you haven't already submitted your claim application form online or over the telephone, the worker will help you fill out the form. The worker will open a file for you, which from then on will contain all of the documents pertaining to your application.

Write down the name of the worker who talks with you, and his or her direct telephone line if available, so that you can speak with the same person if you need to call in to provide or receive further information. The Social Security worker will make copies of the documents you have brought and will explain what other information is needed to process your application.

If additional documents are needed, ask whether you may mail in copies instead of bringing originals in person.

When you first apply, do not expect to be told precisely how much your benefits will be. Exact benefit amounts are based upon the computerized records kept at the Social Security Administration's national records center. Your precise benefit amount will be calculated there.

Applications take six to eight weeks to be processed, but when you receive your first payment, it will include benefits back to the date you first applied, or to the date on which you are first eligible, whichever is later.

5. Withdrawing a Benefits Application

It may happen that after you have turned in your application for retirement, dependents, or survivors benefits, your work situation changes, altering significantly the amount of benefits to which you are entitled. This might, for example, occur if you are offered a new position, a new job, or an increased salary, or you are not laid off from a job you expected to lose, or you are called back to work after a temporary job loss, or you simply change your mind and decide to continue working full time.

In any of these situations, if the income you earn at your continued work significantly exceeds the earnings limit for your age, it may eat up your benefits. If so, your decision to claim benefits may prove to be a bad one, because you will receive little or no benefit payments while you continue to work, and your benefit amount will be permanently lower than if you had waited to file your claim at a later age.

For a limited time after you apply for benefits, however, it is possible to withdraw your application. The limit is 60 days from the date Social Security mails you a notice that your benefits application has been approved. If you are still within this time period, you can go to your local Social Security office and ask to withdraw your application for benefits. A Social Security worker will discuss your decision with you.

If you still want to withdraw your application, the worker will give you a form on which to make a formal request. However, any benefits already paid on the claim must be returned. And a spouse or adult disabled child whose dependents benefits would be affected must consent in writing to the withdrawal of the application.

B. Disability Benefits

Eligibility for disability benefits depends upon your physical or mental condition, and your inability to work because of that condition. (See Chapter 3 for a more detailed account of the eligibility requirements.) Because it involves these qualifying standards, the application requires much more time and effort than other Social Security benefit applications do. You must get and keep your papers organized, and be thorough and persistent in your contacts both with doctors and with Social Security personnel.



Proving that your particular medical condition renders you unable to work may not be easy. This book will give you an introduction, but for more information and specialized advice concerning particular physical and mental conditions, see [Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits](#), by David A. Morton III, M.D. (Nolo).

1. When to File Your Claim

You will not be paid any disability benefits until you have been disabled for six full months. This waiting period begins with the first full month after the date your disability began. That date is usually the date you stopped working because of your physical or mental condition.

However, disability claims take between two and six months to be decided. Do not wait for the six-month period of disability to elapse before filing your claim. Don't even wait to gather all the necessary information and doctors' reports. File the claim as soon as your medical condition forces you off work and the doctors expect that it will prevent you from working for a year or more. You can complete the gathering of necessary documents while the claim is being processed, with the help of your local Social Security office. (For basic filing instructions, see Sections A2 to A4, below.)

2. Documents You'll Need

When you file an application for disability, you'll need to bring a number of documents to the Social Security office:

- Your Social Security number and proof of age (such as a birth certificate) for yourself and any person eligible for dependents benefits.
- Names, addresses, and phone numbers of doctors, hospitals, clinics, and other health service institutions that have diagnosed your medical condition and have given estimates of the length of time it is expected to keep you disabled, plus the approximate dates of your treatment. Although you are not required to produce medical records of your disability—Social Security can request them directly from doctors and hospitals—you might speed up the process if you bring copies of medical records you already have.
- A list of where you have worked in the past 15 years and a description of the kinds of work you did.
- A copy of the past year's W-2 forms, or your last federal income tax return if you are self-employed.
- The dates of any military service.
- Information concerning any other type of disability payment you are receiving.
- If your spouse is applying as a dependent, the dates of any prior marriages. A certified copy of the divorce papers will provide this information.
- If you are applying as a disabled widow or widower, your spouse's Social Security number and a copy of the death certificate.
- If you are applying as a disabled surviving divorced husband or wife, proof that your

marriage lasted ten years; marriage and divorce papers will serve this purpose.

If you are physically unable to get to a Social Security office in person, or you are unable to complete the forms or meet other filing requirements, your application can be completed by your spouse, parent, other relative, friend, or legal guardian. And once the initial claim has been filed, a service worker in the local Social Security office can assist you by having the Social Security office directly request necessary documents.

3. How Your Eligibility Is Determined

Applications for disability benefits go through several stages. Initially, you will fill out an application at a local Social Security office and provide documents regarding your age and employment. After that, however, the process becomes more complicated, as Social Security determines whether your physical condition is actually disabling according to its standards.

a. Disability Determination Services

When your claim has been completed and the local Social Security office has checked to see that you meet all the general requirements regarding work credits for your age (see Chapter 3, Section A, for the work credit requirements), it will forward your claim to a Disability Determination Services (DDS) office in your state. The DDS office will use your medical records and employment history to decide whether you are disabled under the rules of the Social Security law.

Enlisting the Help of Your Doctor

Your medical records will be the biggest factor in the state DDS office's determination of your eligibility for disability benefits. Therefore, what your doctor puts in your records can be all-important.

If possible, discuss the matter with your doctor before you file your application for disability benefits. Inform your doctor that you intend to apply, and ask him or her to make specific notations in your medical records of how your physical activities—particularly work-related activities such as walking, sitting, lifting, carrying—are limited or how your emotional condition affects your ability to regularly perform work. Ask also for your doctor to make a note of when your disability reached a point that it interfered with your ability to work.

Do not ask the doctor to give an opinion about whether you are disabled according to Social Security guidelines. Doctors will readily describe a specific medical condition, but many are unwilling to give an opinion about your ability to do any work at all. And, in any event, the DDS evaluation team would not accept your doctor's opinion on this ultimate question of eligibility. Instead, it will base its determination on its own evaluation of your medical records.

In determining the nature and extent of your disability, the DDS will rely almost exclusively on the diagnoses of medical doctors, as opposed to physical therapists, chiropractors, and other nonphysician healers. This reflects an institutional bias against nontraditional medical treatment. But it also reflects the fact that the decision about eligibility depends on diagnosis of your condition, not on the best way to treat it, and that physicians have diagnostic tools—such as laboratory tests, X-rays, and other technological and intrusive procedures—that are not available to nonphysician healers.

The decision at DDS is made by a doctor and a disability evaluation specialist. They examine all medical records you have provided with your application and may request more information from you, your doctors, and your employers.

Based on these records, the doctor and the specialist determine whether your disability is expected to last more than one year and whether it is severe enough to interfere with your ability to perform any work you have done over the past 15 years. If so, they then determine whether it is also so severe that you cannot perform any substantial gainful work. (See Chapter 3, Section B4, for more on how Social Security determines this.)

If your condition limits you in these ways, you will be found eligible for benefits. If not, those evaluating you may request further medical records and you may be referred for a consultative physical examination.

b. Medical Examinations

In some cases, the DDS evaluators do not feel that they can come to a conclusion about your disability based on your existing medical records. They may request further reports from doctors who have examined or treated you. And they may request that you undergo a medical evaluation or test, called a consultative examination.

The cost of the additional reports, examinations, or tests are paid by Social Security. If you must travel outside your immediate area to get to this examination, Social Security can pay for the cost of that travel, if you request it.

Fortunately, this extra examination or testing is often done by a physician who has already

examined or treated you. This is particularly true if one of your doctors is a specialist in the area of medicine that deals directly with your disability. In other words, if you have seen an orthopedic surgeon for your back problem, Social Security is likely to have that same doctor perform the consultative examination. However, if you have not been treated by a specialist in the field—for example, if only your internist or general practitioner has treated you for a particular medical problem—Social Security may send you to another doctor for this examination.

Consultative examinations are limited to specific issues the DDS needs to clarify regarding your ability to work. The exam often involves certain kinds of tests—a range of motion test, for example, if your disability involves restricted movement—that have not been recently performed by your doctor but which give DDS specific information on the extent of your disability.

The DDS will set up the examination and send the doctor a written request for the information needed and any specific tests it wants performed. The doctor will not conduct a general examination and will not prescribe any treatment for you. On occasion, a representative from DDS will attend the examination to record specific test results. The doctor will send a report to DDS describing the results of the examination, but he or she will not take part in the final decision about whether you are eligible for disability benefits.

Even though you may not be thrilled by the idea of going through another medical examination, especially if it is by a doctor you do not know, you must cooperate with the DDS to successfully process your disability claim.

c. Vocational Rehabilitative Services

When you apply for disability benefits, you may be referred to your state's vocational rehabilitation agency for a determination of whether any of its services might be of help to you. These free services can include job counseling, job retraining and placement, and specialized medical assistance. The services can also train you to use devices—such as a modified computer keyboard—that may enable you to work despite your disability.

C. Supplemental Security Income (SSI)

You may file a claim for SSI benefits at your local Social Security office at the same time you file for retirement, disability, dependents, or survivors benefits. (See Chapter 6 for a full discussion of the SSI program.) However, SSI is not automatically included in these other applications, so you must tell the Social Security worker that you wish to file for SSI benefits as well.

If you believe you might be close to the qualifying income and asset limits for SSI benefits, go ahead and apply. If your state offers a separate state-administered supplementary payment in addition to the basic federal SSI payment, you will have to apply for that supplement at your local county social welfare office.

The process of applying for SSI benefits is very similar to applying for Social Security benefits. You will need to provide the same general

documents. (See Sections A1 and A2, above, for instructions.) However, unlike Social Security benefit applications, SSI benefit applications also require that you show records of your income and assets.

I. Proof of Income and Assets

Regardless of whether you are applying for SSI payments as disabled or over age 65, you must also bring information regarding your income and assets. This includes:

- information about where you live: for homeowners, a copy of your mortgage papers or tax bill; for renters, a copy of your rental agreement or lease and the name and address of the landlord
- documents indicating your current earned income, such as pay stubs and income tax returns
- papers showing all your financial assets, such as bankbooks, insurance policies, stock certificates, car registration, burial fund records, and
- information about your spouse's income and assets, if the two of you live together.

Even if you do not have all these papers available, go to your local Social Security office and file your application for SSI as soon as you think you may qualify for assistance. The Social Security workers can tell you how to get whatever papers and records are necessary, and in some instances will get copies of the required records for you.

2. Proof of Age If 65 or Over

If you are age 65 or over, bring your Social Security number and proof of your age, such as a birth certificate. If you do not have a birth certificate, bring any other evidence of the date of your birth: baptism record, military papers, immigration papers, driver's license, passport. If you are already receiving any kind of Social Security benefit, you do not have to bring proof of your age.

3. Proof of Blindness or Disability

The process for proving that you are blind or disabled for purposes of SSI benefits is the same as the process when qualifying for Social Security disability benefits. (See Chapter 3, Section B, for the eligibility requirements.) The information you need to gather and the process of applying for disability benefits is discussed in Section B of this chapter, above.

4. Proof of Citizenship or Qualifying Legal Residence

For a reminder of what immigration status you must hold in order to qualify for SSI, see Chapter 6, Section A2.

If you are a U.S. citizen, you'll need to prove your citizenship by showing copies of your birth certificate, baptismal records, U.S. passport, or naturalization papers.

If you are a noncitizen, bring proof of your qualifications under one of the categories listed in Chapter 6.

For proof of work for ten years, bring your legal resident alien card ("green card") and Social Security numbers for yourself and your spouse. The Social Security or local welfare office will use the numbers to check your reported Social Security taxes.

If you seek to qualify as a veteran of the U.S. armed forces, bring evidence of honorable discharge from the military. You will also need a copy of your marriage certificate if you are seeking SSI as the spouse of a veteran.

D. Finding Out What Happens to Your Claim

You will not find out from your local Social Security office whether your claim for benefits has been approved; that word has to come from the Social Security Administration in Washington, DC. If your claim is approved, you will have several methods of payment from which to choose.

I. Notification of Eligibility

Social Security will notify you in writing whether your claim has been approved, how much your benefits will be, and when you will get your first check.

From the time the application is filed, a retirement, dependents, or survivors claim usually takes from four to eight weeks. A disability claim can take up to six months. For all types of claims, you will receive benefits dating back to the date you first applied, or first became eligible if you applied before you reached an age of eligibility.

SSI benefits usually begin four to eight weeks after you completed the necessary paperwork. If your claim is based on a disability that has not already been established for Social Security disability payments, it may take three to six months. When you do finally get your money, however, it will cover the entire period from the time you filed your claim.

If you were unable to work for more than six months before applying for disability benefits, you might be eligible for back benefits. If Social Security determines that your disability actually began more than six months before your application, based on when you actually stopped work, it can grant up to 12 months of back benefits.

If your claim for any Social Security or SSI benefit is denied, the written notice of denial will state the reasons why. You have a right to appeal a denial of your claim. Your appeal must be submitted within 60 days from the date you receive written notice of the denial or other decision. (See Chapter 8, Section A, for appeal procedures.)

When You Need Money in a Hurry

It is possible to get some SSI payments even before your claim is finally approved. If you appear to be eligible for SSI and you need immediate cash to meet a financial emergency, the Social Security office can issue you an advance payment. The amount of this emergency payment will be deducted from your first regular SSI check.

Similarly, if you have already qualified for Social Security disability benefits and you appear financially eligible, you may be approved for and begin receiving SSI benefits immediately, without medical review.

If you are financially eligible and appear to meet the disability requirements, but your disability application has not yet been approved by Social Security, you can receive SSI payments for up to three months while your claim is being reviewed by the disability office.

2. Methods of Receiving Payment

All new beneficiaries are expected to receive their Social Security and SSI benefits by direct deposit into their bank accounts. However, it is possible to receive payment by government check sent directly to you through the mail or to someone who handles the money for you, called a substitute payee. You must indicate on the application if you want these options. You may change your method of payment any time after you begin to receive benefits.

a. Direct Deposit

Direct deposit has a number of advantages: You do not have to wait for your check to arrive in the mail, nor do you have to travel to your bank to make the deposit. And you do not have to worry about your check being lost or stolen.

When you first sign up for benefits at your local Social Security office, workers there will ask for the name and address of your bank branch and the number of the account where you want the funds deposited. The bank where you have your account can help you fill out the form to request direct deposit.

If you change banks—or want to close one account and open another—you must fill out a new direct deposit form. The bank where you open your new account will assist you with the form. But do not close your old account until you see that your benefit has appeared in your new one. If your benefit continues to be deposited in the old account, contact your local Social Security office.

b. Checks Through the Mail

Social Security now strongly urges everyone to use direct deposit. But you may not want to receive your payment this way, either temporarily or for the long term. For example, you may not want to pay the bank charge to maintain an account. Or, you may be moving and temporarily will not have a local bank account. If, for any reason, you do not want to receive your benefit payment by direct deposit, you may arrange with your local Social Security office to have your payments mailed in the form of a check.

All Social Security and SSI checks sent through the mail arrive at about the same time—close to the third day of every month. If your check does not arrive on or near its usual day, call your local Social Security office right away to report it lost. The local office can then start the process of getting you a replacement check. This usually takes 20 to 30 days.

c. Substitute Payee

If you are unable to handle your own banking and check writing, you may have a family member, close friend, or legal representative receive the benefit payments on your behalf. That person should spend the money according to your wishes or directions. This may be done informally, by simply adding the other person as a joint account holder on the bank account where Social Security deposits your check. The bank can make this arrangement for you.

If you feel more comfortable with some oversight on how that person spends your benefits, you can have this other person officially appointed by Social Security as a substitute or representative payee. That person would then personally receive the benefit payments on your behalf.

Anyone proposing to be your substitute payee must bring to the local Social Security office medical proof—for example, a letter from your doctor—that you are unable to care for yourself. The substitute payee must sign a sworn affidavit at the Social Security office stating that he or she will use the Social Security check for your benefit. The Social Security office will then verify your medical condition and the identity of the substitute payee.

If a person has already been appointed by a court to serve as legal guardian or conservator, proof of that court appointment is all that is required to be appointed representative payee. But people who are named to act in powers of attorney do not automatically qualify as representative payees; they must still apply for representative payee status at the local Social Security office.

The rules require that a substitute payee deposit and keep the money belonging to the person entitled to Social Security in a separate bank account, and periodically file an accounting with Social Security to show how the money has been spent to care for the beneficiary. The substitute payee should keep all bills and receipts in a systematic and organized way so they can be produced easily.

Periodic Review of SSI Eligibility

Social Security periodically reviews your SSI eligibility and the amounts you receive. These reviews take place at least once every three years, although there may be a brief review of your finances annually. When you receive a notice of review, you will have to produce the same kinds of information as you did for the original application: your income, assets, living arrangements, and, if claiming based on a disability, updated medical information. Often, most of this process can be handled by mail or telephone, although you may have to make a trip to the Social Security office for an interview.





Appealing a Social Security Decision

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No matter how certain you feel that you deserve Social Security benefits, the agency may have other ideas, and deny your claim. Sometimes this is a mere mistake and can be corrected. More often, the decision was a matter of judgment, as with disability claims, where questions about medical conditions, ability to work, or income levels (in SSI cases) are subjective and susceptible to different interpretations.

But if your application for benefits is initially denied, or is granted but you are awarded less than you had hoped, that need not be the end of the matter. Virtually all decisions of the Social Security Administration may be appealed, and many appeals are successful. Whether a new benefit has been denied or an existing benefit reduced or ended, you may appeal the decision as long as you follow some fairly simple rules and are willing to think creatively about how to present your case in a more convincing way. You'll need to put yourself into the shoes of the Social Security workers who first denied your claim, try to understand their reasoning, and then provide convincing evidence so that the next person who sees your file won't view your claim in exactly the same way.

This chapter explains the four possible levels of appeal following any Social Security decision. The first is called reconsideration; it is an informal review that takes place in the local Social Security office where your claim was filed. (Technically, this isn't really an "appeal," because it doesn't go to a higher authority—but it's a step that you must take, nonetheless.)

The second level is a hearing before an administrative law judge ("ALJ"); this is an inde-

pendent review of what the local Social Security office has decided, made by someone outside the local office. The third level is an appeal to Social Security's national Appeals Council in Falls Church, Virginia. And the final level is filing a lawsuit in federal court.

**Get extra advice regarding disability appeals.**

More than 90% of all Social Security appeals involve claims for disability benefits (including SSI). Most of these appeals revolve around whether the claimant's physical or mental condition actually prevents gainful employment. Proving this requires careful presentation of medical information as well as completing certain special forms. This book will give you an introduction to this process, but for more information and specialized advice for various physical and mental conditions, see [*Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits*](#), by David A. Morton III, M.D. (Nolo).

**Beware of the time limit for filing appeals.**

The same time limit applies to each step of the appeals process. From the date on the written notice of Social Security's decision—whether denying or granting a benefit—you have 60 days within which to file a written notice that you are appealing that decision to the next stage in the process. If you receive the notice by mail, you have an additional five days within which to file your notice of appeal.

A. Reconsideration of Decision

When a claim for any type of Social Security benefit—retirement, disability, dependents, or survivors—is denied, or an existing benefit is ended, or you receive an amount you feel is less than that to which you are entitled, the first step to appeal that decision is to request reconsideration.

If the negative decision involved a denial of benefit claims, see the procedures discussed in Sections A1 through A3, below. And some special procedures to follow when appealing denial of an SSI claim are discussed in Section A4, below.

Is an Appeal Worth the Effort?

The first question that may occur to you when considering an appeal is whether it is worth the effort.

Let's start with some encouraging numbers: A substantial percentage of decisions are changed on appeal. Almost half of all disability appeals, which are by far the most common, are favorably changed in the appeal process.

And appealing a Social Security claim need not be terribly difficult. If you properly organized and prepared your original claim, most of your work for the appeal has already been done. In many situations, the appeal will require little more from you than explaining once more why the information you already presented should qualify you for a benefit. In other cases, it will simply involve presenting one or two additional pieces of information that better explain your situation to Social Security personnel.

A negative Social Security decision may affect your rights for many years. Because it is so important, and because the appeal process is relatively simple, it is almost always worth the effort to appeal.



Get the most recent forms. This chapter will tell you which forms you'll need. But when you're ready to fill them out, one of the best ways to make sure you're using up-to-date forms is to get them from the Social Security website at www.ssa.gov. Under the Resources heading, click "Forms." Then click on "Other Forms" to find the ones needed for an appeal. Your local Social Security office also has the required forms. Or you can order forms by calling the Social Security office at 800-772-1213.

I. Requesting Reconsideration of Decision on Initial Benefits Claim

The first formal step in appealing the denial of a claim for retirement, disability, dependents, or survivors benefits is to file a written request for review of the decision, called a *Request for Reconsideration* (SSA 561-U2).

This is also the step you take if you are allotted benefits less than the amount to which you believe you are entitled. A sample of the form follows.

The form is in duplicate: a top copy for the Claims Folder (the Social Security office's copy) and a bottom Claimant's Copy (for you). You fill in only the top part of the form. The information requested is straightforward: name, address, Social Security number, and type of claim—retirement, disability, dependents, or survivors.

If you cannot get the actual form in time to file it within the 60-day limit, copy the form in this book and submit it to your local Social Se-

curity office. Be sure to keep a copy of the completed form for your records.

2. Completing the Form

The first few lines of the *Request for Reconsideration* form are fairly simple. On the top left, fill in your own name, exactly as it appears on your Social Security card.

Use the box on the top right only if you are claiming dependents or survivors benefits; if so, put the name of your spouse or parent on whose work record you are claiming benefits.

On the second line to the left is the box for the Social Security claim number. Copy that number from the written denial of your claim that you received from Social Security.

The remaining boxes on the top three lines apply only if you are appealing the denial of SSI benefits. If so, you must fill in your spouse's name and Social Security number so that the agency can check his or her earnings. And on the middle line to the right, you must note your SSI claim number, which you will find on the written denial of your SSI claim.

The most important part of the form comes on the lines following the words: "I do not agree with the determination made on the above claim and request reconsideration. My reasons are: ...". On those lines, state briefly and simply why you think you were unfairly denied your benefits.

You need not go into great detail, because your entire file will be examined—including any additional materials you want to submit. Your statement should simply identify the problem,

such as: "The decision that I am not disabled was based on insufficient evidence about my condition. I am submitting an additional letter from my doctor about my condition." Or: "The DDS evaluation of my disability did not take into account my inability to sit for prolonged periods."

Along with your completed *Request for Reconsideration* form, you may submit a form called a "Reconsideration Report for Disability Cessation" (SSA-782-BK) to explain any changes in your condition since you filed your original claim for benefits. How to fill out this form is further explained in [Nolo's Guide to Social Security Disability: Getting & Keeping Your Benefits](#), by David A. Morton III, M.D. (Nolo). In addition, you can submit a letter describing in more detail why you think Social Security's decision was incorrect.

If they're relevant, you should also submit other materials to your file, such as recent medical records or a letter from a doctor or employer about your ability to work. Such new material may be crucial to winning your reconsideration request—government workers have a tendency to believe that their agency was right the first time, unless you give them something new and different to change their minds.

This additional information does not have to be submitted by the 65th day after the written decision. But if you are planning to submit it after your *Request for Reconsideration*, indicate this on the form. (Use the space where you explain your disagreement with the decisions.)

Be sure to include your Social Security number and your claim number, in addition to your full name and the date, on all material you send in. And keep a copy for your records.

SOCIAL SECURITY ADMINISTRATION		TOE 710		Form Approved OMB No. 0960-0622	
REQUEST FOR RECONSIDERATION				<i>(Do not write in this space)</i>	
NAME OF CLAIMANT		NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON <i>(If different from claimant)</i>			
SOCIAL SECURITY CLAIM NUMBER		SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) CLAIM NUMBER			
SPOUSE'S NAME <i>(Complete ONLY in SSI cases)</i>		SPOUSE'S SOCIAL SECURITY NUMBER <i>(Complete ONLY in SSI cases)</i>			
CLAIM FOR <i>(Specify type, e.g., retirement, disability, hospital insurance, SSI, SVB, etc.)</i>					
I do not agree with the determination made on the above claim and request reconsideration. My reasons are:					
SUPPLEMENTAL SECURITY INCOME OR SPECIAL VETERANS BENEFITS RECONSIDERATION ONLY (See reverse of claimant's copy) "I want to appeal your decision about my claim for supplemental security income (SSI) or special veterans benefits (SVB). I've read the back of this form about the three ways to appeal. I've checked the box below."					
☐ Case Review ☐ Informal Conference ☐ Formal Conference					
EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH					
I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.					
CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ NON-ATTORNEY ☐ ATTORNEY		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (Include area code)		DATE	TELEPHONE NUMBER (Include area code)		DATE
TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION					
See reverse of claim folder copy for list of initial determinations					
1. HAS INITIAL DETERMINATION BEEN MADE?		☐ YES ☐ NO	2. CLAIMANT INSISTS ON FILING		☐ YES ☐ NO
3. IS THIS REQUEST FILED TIMELY? <i>(If "NO", attach claimant's explanation for delay and attach only pertinent letter, material, or information in social security office.)</i>		☐ YES ☐ NO			
RETIREMENT AND SURVIVORS RECONSIDERATIONS ONLY (CHECK ONE) REFER TO (GN 03102.125)				SOCIAL SECURITY OFFICE ADDRESS	
☐ NO FURTHER DEVELOPMENT REQUIRED (PGN 03102.125P)					
☐ REQUIRED DEVELOPMENT ATTACHED					
☐ REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS					
ROUTING INSTRUCTIONS (CHECK ONE) →		☐ DISABILITY DETERMINATION SERVICES (ROUTE WITH DISABILITY FOLDER)		☐ PROGRAM SERVICE CENTER	
		☐ ODO, BALTIMORE		☐ DISTRICT OFFICE RECONSIDERATION	
		☐ OIO, BALTIMORE		☐ CENTRAL PROCESSING SITE (SVB)	
		☐ OEO, BALTIMORE			
NOTE: TAKE OR MAIL COMPLETED COPIES TO YOUR SOCIAL SECURITY OFFICE					
Form SSA-561-U2 (9-2002) ef (10-2002) Destroy Prior Editions			TAKE OR SEND ORIGINAL TO SSA AND RETAIN A COPY FOR YOUR RECORDS		

The Importance of Reviewing Your File

Sometimes a Social Security or SSI claim is denied because a document or other piece of information that should be in your file is not there. Or perhaps some misinformation has gotten into your file without your knowledge. This happens most often on the question of medical condition, where an incomplete medical record is in your file, or the report from the DDS examination includes a mistake based on a misunderstanding with the doctor who did the examination.

The only way for you to find out if such mistakes exist is to look at your file, which should contain all documents related to your claim. After you file your *Request for Reconsideration*, call your local Social Security office to set up an appointment to see your file.

If you find a mistake in the file, write a letter to Social Security explaining the situation. Send the letter to your local Social Security office, asking that it be made part of your file for reconsideration. And, as always, keep a copy of the letter.

3. The Reconsideration Process

Your claim will be reconsidered by someone in the Social Security office other than the person who made the decision on it the first time around. He or she will consider everything that was in your file when the decision was made,

plus anything you have submitted to the office since the original decision.

Generally, you do not appear in person at this review; you do not have the right to speak face to face with the person making the decision, although you can request a chance to do so. The person doing the review may request more information and may ask you to come in for a further informal interview.

You will receive a written notice of the decision made on your request for reconsideration—usually within 30 days. If 30 days go by with no word, contact the local Social Security office and ask about the delay. Reconsideration of a disability claim often takes two to three months, particularly if new medical information has been provided during the course of the appeal.

Once you receive your written decision, you can, if the decision is negative, file a request for an administrative hearing if you want one. (See Section B, below, regarding administrative hearings.) You must file your request within 65 days of the date on the written decision.

Continuing Your Benefits During an Appeal

In some circumstances, you can continue to receive Social Security disability benefits and SSI benefits while Social Security is deciding your appeal. You can request this if:

- you have been collecting Social Security disability benefits and you are now appealing Social Security's decision to end your benefits because it has determined that your condition has improved, or
- you have been collecting SSI benefits and Social Security has decided that you are no longer eligible, or that you are eligible for lower benefits.

If you want your benefits to continue during the appeal process, you must make the request to your local Social Security office within ten days of the date you receive a written notice ending or reducing your benefits.



Continued benefits may not be for keeps.

If you continue to collect benefits while appealing Social Security's decision to end those benefits, and Social Security denies your appeal, you may have to pay back the benefits you received during the appeal process.

4. Requesting Reconsideration of SSI Decision

If you request a reconsideration of a decision regarding a claim for SSI benefits, you'll be asked to choose among three possible procedures listed on the *Request for Reconsideration* form. Which one you choose depends upon how and why you were denied:

- If Social Security denied your claim for SSI because it says that you are not disabled, you are entitled only to what is called a "case review." This means that you can add more documentation to your file, which will then be reviewed again. You will not, however, be permitted to meet face to face with the Social Security representatives deciding your claim.
- If your claim for SSI benefits was denied for nonmedical reasons—such as your immigration status, or your income and asset levels—you may request an "informal conference." This permits you to speak with the person reviewing your claim and to show additional documents. You can also bring along anyone you want to help support your argument.
- If you have been receiving SSI benefits but Social Security decides to end or reduce them, you can request a "formal conference." This is actually an informal meeting at which you can present whatever written materials you want, have people come to the meeting and give information, and also explain your situation in your own words. It is only formal in the sense that the Social Security office can issue a legal summons for people to show up and answer questions if they refuse to come voluntarily. If you want Social Security to force someone to appear, you must notify your local office several weeks before the hearing date.

Informal Hearings at Social Security

There are several instances in which you might have an opportunity to meet with the Social Security representative who is reviewing your file. This might be during the initial reconsideration of your retirement, disability, dependents, or survivors claim, as discussed in Sections A1 through A3. Or, it might be during the informal or formal conference regarding an SSI claim explained in Section A4.

In any of these situations, the meeting itself will be very informal. You will be given the chance to explain, in your own words and in person, why you believe the decision denying or ending your benefits was wrong.

There are several things to bear in mind during one of these meetings:

- Focus on addressing whatever reason Social Security gave (in the notice denying or ending your benefits) to justify its decision. Perhaps it was your physical condition, changes in your condition, your income, or your work hours. Be strong and direct in explaining why their reasoning was wrong. Don't make the mistake that some people do and dilute your argument by telling your whole life story or explaining your whole medical history.
- If, along with your appeal, you submitted material that was not in your original file, ask whether the representative has had a chance to read it. If so, explain how the new material shows that the original decision was incorrect. If not, give the representative copies of these new materials and ask that he or she read them before you continue with the meeting.
- The Social Security representative has access to all the the documents in your file. There is no need to go over them all or read them aloud except to point out what you believe are errors, or to focus on something in a document that you believe is important but that seemed to have been ignored in the original decision.
- A Social Security representative who asks a question is probably doing so to focus in on what Social Security considers important. Do not dismiss or ignore the question. Try to answer it as well and as directly as you can. If there is other information—from your doctor or employer, for example—that you believe might help answer the question, tell the representative and either direct the representative to an existing document in your file, or ask that you be allowed to provide the information before the representative makes a decision.
- Be calm and polite. Social Security representatives understand that the ending of benefits is an emotional matter for you, but they are not the person who made the initial decision, and they are human, so you will not do yourself any good by taking out your frustration on them.

B. Administrative Hearing

If Social Security denies your claim again after reconsidering it, you may request a formal administrative hearing. The hearing will be held in front of an independent administrative law

judge. The people in the office that denied your claim won't take part in the judge's decision making. That means you have a good chance of having the denial of your claim reversed at this hearing, even if you have no new information to present.

1. Requesting a Hearing

As with other steps in the appeal process, you must file a request for this hearing with your local Social Security office within 65 days of the date on the written notice of the decision after reconsideration.

Your request must be filed on a form called *Request for Hearing by Administrative Law Judge* (HA-501), reproduced below.

Section 2, below, describes how to fill out this form. Be sure to make copies for your file. If you have additional questions, your local Social Security office can help you out.



Consider getting assistance with hearing preparation from an outside professional, such as a lawyer or other counselor specializing in Social Security matters. This is particularly true if the issue is whether your physical or emotional condition qualifies you as disabled, because you'll need to gather and present evidence that's convincing enough to sway a judge's subjective determination. Your best chance of reversing Social Security's decision comes at the administrative hearing, and so you will want to be as well prepared as possible at this stage.

2. Completing the Form

The first four sections of the form, along the same top line, are straightforward. Your name goes in box number 1, as Claimant.

If you are seeking dependents or survivors benefits, then you must also fill in box number 2 with the name of the spouse or parent on whose earnings record you are claiming benefits. Box 3 simply asks for your claim number and Box 4 for that of your spouse, if this is an SSI claim.

Section 5 of the *Request for Hearing by Administrative Law Judge* form asks for you to state the reasons you disagree with the determination made on your claim. State your reasons here simply and briefly, for example: "The decision that I am not disabled was based on incorrect statements about the number of hours I regularly work. I am submitting letters from my coworkers explaining that I actually work fewer hours than stated in the decision ending my benefits." Or: "The DDS evaluation of my disability did not take into account my inability to travel to and from work."

Section 6 includes two boxes to indicate whether you have additional evidence to submit. You should always check the second box—the one that says you do have additional evidence. This will allow you to submit a new written statement to the judge, as well as any letters or documents that were not already in your file. If it turns out that you do not have any additional letters or documents to submit, at the hearing you can inform the judge that you have no new written materials but would like an opportunity to speak.

After you and your representative have organized your papers and spoken with your doctor, your employer, or another person who can provide additional or clarifying information about your claim, you, or you and your representative, should write a detailed statement summarizing and arguing your claim. Send that statement to your local Social Security office to be placed in your file, and also directly to the administrative law judge who will hear your claim. Do this at least two weeks before your hearing date so that the administrative law judge will have a chance to read the statement before the hearing. If you do not prepare it in advance, bring it with you to the hearing and present it there.

In Section 7 on the hearing request form, you must indicate whether you want to attend the hearing in person. If you don't, the judge will make a decision based on the papers in your file. It is almost always to your advantage to be present at the hearing. Your presence puts a human face on your claim and shows the judge that you are truly concerned about the outcome. It also allows the judge to ask you questions that might not get answered if you were not there.

If you check "yes" in Section 7 but later decide not to attend the hearing, you must notify the hearing judge's office beforehand. If, on the other hand, you checked the box saying that you do not want to attend the hearing but later decide you do, contact the hearing judge's office

as soon as you can. The hearing will probably have to be rescheduled to a later date. That is because hearings with the claimant present are usually scheduled at different times and places than hearings consisting solely of a review of the file.

Section 9 asks you to write the name and address of your representative. If you do not have a representative by the time limit for filing your request for hearing, file the request without naming anyone. If later you obtain a representative, you can supply that information then.



Timing may be important. To make sure that all your evidence gets in your file and to the administrative law judge in time for your hearing, you must submit all new evidence—letters, documents, records that were not previously given to Social Security—within ten days of filing your request for a hearing. So, even if you are ready to file a request for an administrative hearing immediately after you receive written notice of the reconsideration decision, it is a good idea to wait until you have gathered whatever additional information you want the hearing judge to see. This may delay slightly the date of your hearing, but it will allow you to make sure all your evidence will be considered there.

SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0269

REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

(Take or mail original and all copies to your local Social Security office,
the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post)

See Privacy Act
Notice on Reverse

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT	3. SOC. SEC. CLAIM NUMBER	4. SPOUSE'S CLAIM NUMBER
-------------	------------------------------	---------------------------	--------------------------

5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination made on my claim because:

An Administrative Law Judge of the Office of Hearings and Appeals will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. ☐ Yes ☐ No Name and address of source of additional evidence: _____ (Please submit it to the Social Security office, The Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post within 10 days. Attach an additional sheet if you need more space.)	7. Check one of the blocks: ☐ I wish to appear at a hearing. ☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)
---	--

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. (If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative).)

[You should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 9.]

8. (CLAIMANT'S SIGNATURE)	(DATE)	9. (REPRESENTATIVE'S SIGNATURE/NAME)	(DATE)
ADDRESS		(ADDRESS) ☐ ATTORNEY; ☐ NON ATTORNEY;	
CITY	STATE	ZIP CODE	CITY
STATE	STATE	STATE	STATE
TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION-ACKNOWLEDGMENT OF REQUEST FOR HEARING

10. Request received for the Social Security Administration on _____ by: _____			
(Date)		(Print Name)	
(Title)	(Address)	(Servicing FO Code)	(PC Code)
11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO			
If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.			
12. Claimant is represented ☐ Yes ☐ No		15. Check all claim types that apply:	
☐ List of legal referral and service organizations provided		☐ RSI only (RSI) ☐ Title II Disability-worker or child only (DIWC) ☐ Title II Disability-Widow(er) only (DIWW) ☐ SSI Aged only (SSIA) ☐ SSI Blind only (SSIB) ☐ SSI Disability only (SSID) ☐ SSI Aged/Title II (SSAC) ☐ SSI Blind/Title II (SSBC) ☐ SSI Disability/Title II (SSDC) ☐ HI Entitlement (HIE) ☐ Title VIII Only (SVB) ☐ Title VIII/Title XVI (SVB/SSI) ☐ Other - Specify: _____	
13. Interpreter needed ☐ Yes ☐ No			
Language (including sign language): _____			
14. Check one: ☐ Initial Entitlement Case			
☐ Disability Cessation Case			
☐ Other Postentitlement Case			
16. HO COPY SENT TO: _____ HO on _____			
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; or			
☐ Title II CF held in FO to establish CAPS ORBIT; or			
☐ CF requested ☐ Title II; ☐ Title XVI ☐ Title VIII			
(Copy of teletype or phone report attached)			
17. CF COPY SENT TO: _____ HO on _____			
☐ CF Attached: ☐ Title II; ☐ Title XVI			
☐ Other Attached: _____			

3. Preparing for the Hearing

During the time between filing your request for a hearing and the hearing date, you should take several steps.

First, discuss your claim with the attorney or representative who will assist or represent you at the hearing. (See Section E, below, for suggestions on obtaining legal representation.) It is particularly important to make sure that your representative understands what you believe to be the most important part of your claim and that he or she has thoroughly reviewed any documents that you believe support your position.

Second, examine your file, either at your local Social Security office or at the hearing office. This allows you to see that all the papers you have given to Social Security have found their way into your file. It also allows you to review all of both the positive and negative information that Social Security has collected, such as a report on your disability from a DDS examination. Call your local Social Security office to see when and where you can examine your file.

Finally, ask for letters or records from your medical providers or employers establishing your claim and responding to the reasons expressed by the Social Security office or DDS examiners for rejecting your claim. Submit copies to your local Social Security office and directly to the administrative law judge, while keeping the original and at least one more copy.

4. The Hearing

After you file the request for hearing, you will be notified by mail of the hearing date and place. You'll receive this notice at least three or four weeks before the hearing.

If you cannot attend on that date, contact the office of the administrative law judge and arrange for a new date. Act quickly: Most offices of administrative law judges are reasonable about rescheduling, but if you wait until the last week to request a change, and you do not have a medical or other valid emergency, the judge could refuse to postpone your hearing. In that case, the judge would hold the hearing without you.

The hearing itself is conducted in a style less rigid than in a traditional courtroom but a bit more formal than a hearing at the local Social Security office. An administrative law judge presides, and everything said or done is recorded. You may be represented or assisted at the hearing by a friend or relative or by a lawyer or other advocate. (See Section E, below, regarding getting legal or other help.)

You may present any evidence you would like the judge to consider—including documents, reports, and letters. And you may present the testimony of any witnesses you would like to have help prove your claim. This testimony is also informal. The person simply gives information regarding your employment or medical condition to the judge and answers any questions from the judge. The judge will give you an opportunity to explain your claim in your own words, and may also ask you some questions.

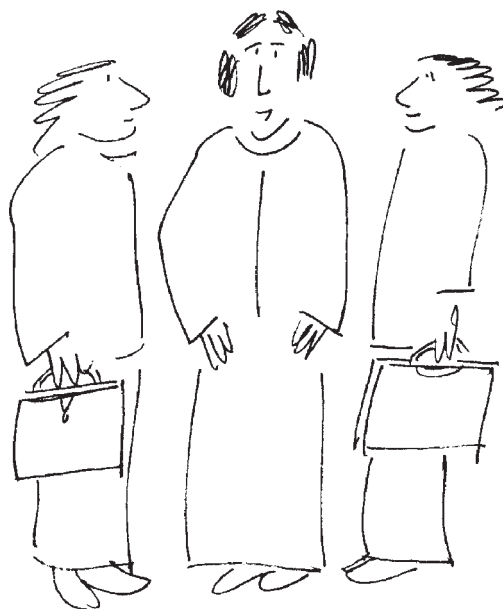
The administrative law judge who presides at your hearing is a lawyer who works for the So-

cial Security Administration. He or she must not have taken part in the original claim decision or in reconsidering your claim. The judge will follow certain rules of procedure and may ask you questions about your claim that are not easy to answer. In general, however, the judges try to be as helpful as possible. If you are not sure how to present certain information to the judge, explain the problem and the judge should help you get the information into the official record of the case.

The judge will issue a written decision on your appeal, usually within four to six weeks of the hearing. You will receive a copy of this decision in the mail. If your claim has been denied, you will have 65 days from the date on the written notice of the denial to file a further appeal. If your claim has been approved, you may be entitled to receive benefits dating all the way back to the time you filed your original claim.

C. Appeal to the National Appeals Council

If your appeal has been denied after an administrative hearing, your next step is to file a written appeal with the Social Security Administration Appeals Council. You must file this within 65 days from the date on the written notice of the administrative law judge's decision.



I. Completing the Form

The form you'll need at this stage of the appeals process is called "*Request for Review of Hearing Decision/Order*" (HA-520 U5).

The form is fairly straightforward, asking only that you give a brief explanation of why you think the administrative law judge's decision was wrong. If there's more to say than can be fit onto this form, attach a separate piece of paper with the explanation. Also submit any documents which the judge did not consider

but which you believe are important to your claim.

On Question 11 of the form, you'll be asked to check either "Initial Entitlement" or "Termination or other." Initial Entitlement means you were denied after your first attempt to obtain a particular benefit. Termination or other refers to when you were already receiving a benefit but Social Security decided to end it or to reduce the amount you receive.

Also notice the explanation in the middle of the form under the heading Additional Evidence. Any documents you wish to submit to the Appeals Council that are not already in your file must be either attached to the form or sent directly to the Appeals Council within 15 days after filing your request for review.



If you are not yet represented by a lawyer who specializes in Social Security matters, hire one now. The Appeals Council usually reverses an administrative law judge's decision only when a technical argument can be made as to why the administrative law judge made a legal mistake. Simply arguing to the Appeals Council that the judge was wrong in deciding your case will not be enough.

2. Appeal Procedure

Unfortunately, your appeal to the Appeals Council is not likely to meet with much success. The Appeals Council usually reviews a case based on the written documents in your file only. It very rarely accepts a case for a hearing, and when it does, the Council meets only in Falls Church, Virginia. If you want to appear at the hearing, you have to go or send a representative to the hearing in Washington.

More often, if the Appeals Council believes there is some merit to the appeal, it sends the case back to the administrative law judge with the direction that the judge hold a new hearing and reconsider something the Appeals Council will point out in its written decision.

Although the success rate of having claims denials overturned by the Appeals Council is very low, filing an appeal may be important. You are required to file this appeal before you can move on to the next step, which is filing a lawsuit in federal court.

D. Lawsuit in Federal Court

If your claim has been denied and you have unsuccessfully exhausted all the Social Security Administration appeals procedures, you are entitled to bring a lawsuit against the Social Security Administration in federal district court. You must file the initial papers of this lawsuit within 60 days after the Appeals Council's decision is mailed.

SOCIAL SECURITY ADMINISTRATION/OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB No. 0960-0277

REQUEST FOR REVIEW OF HEARING DECISION/ORDER

(Do not use this form for objecting to a recommended ALJ decision.)

(Take or mail original and all copies to your local Social Security office,
the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post)

See Privacy Act
Notice on Reverse

1. CLAIMANT	2. WAGE EARNER, IF DIFFERENT
3. SOCIAL SECURITY CLAIM NUMBER	4. SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (Complete ONLY in Supplemental Security Income Case)

5. I request that the Appeals Council review the Administrative Law Judge's action on the above claim because:

ADDITIONAL EVIDENCE

If you have additional evidence submit it with this request for review. If you need additional time to submit evidence or legal argument, you must request an extension of time in writing now. If you request an extension of time, you should explain the reason(s) you are unable to submit the evidence or legal argument now. If you neither submit evidence or legal argument now nor within any extension of time the Appeals Council grants, the Appeals Council will take its action based on the evidence of record.

IMPORTANT: Write your Social Security Claim Number on any letter or material you send us.

SIGNATURE BLOCKS: You should complete No. 6 and your representative (if any) should complete No. 7. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc. in No. 7.

DATE		☐ ATTORNEY ☐ NON-ATTORNEY	
6. CLAIMANT'S SIGNATURE		7. REPRESENTATIVE'S SIGNATURE	
PRINT NAME		PRINT NAME	
ADDRESS		ADDRESS	
(CITY, STATE, ZIP CODE)		(CITY, STATE, ZIP CODE)	
TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER

THE SOCIAL SECURITY ADMINISTRATION STAFF WILL COMPLETE THIS PART

8. Request received for the Social Security Administration on _____ by: _____			
(Date)		(Print Name)	
(Title)	(Address)	(Servicing FO Code)	(PC Code)

9. Is the request for review received within 65 days of the ALJ's Decision/Dismissal? ☐ Yes ☐ No

10. If no checked: (1) attach claimant's explanation for delay; and
(2) attach copy of appointment notice, letter or other pertinent material or information in the Social Security Office.

11. Check one: ☐ Initial Entitlement ☐ Termination or other	12. Check all claim types that apply: ☐ Retirement or survivors (RSI) ☐ Disability-Worker (DIWE) ☐ Disability-Widow(er) (DIWW) ☐ Disability-Child (DIWC) ☐ SSI Aged (SSIA) ☐ SSI Blind (SSIB) ☐ SSI Disability (SSID) ☐ Health Insurance-Part A (HIA) ☐ Health Insurance-Part B (HIB) ☐ Title VIII Only (SVB) ☐ Title VIII/Title XVI (SVB/SSI) ☐ Other - Specify: _____
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APPEALS COUNCIL
OFFICE OF HEARINGS AND APPEALS, SSA
5107 Leesburg Pike
FALLS CHURCH, VA 22041 - 3255

Form HA-520-U5 (9-2001) EF (4-2002)
Destroy Prior Editions

CLAIMS FOLDER

A federal court lawsuit is a complicated, time-consuming, and expensive procedure. However, it may be worth it. When you add up the total amount of benefits you might receive in your lifetime if your claim is approved, there may be a lot of money at stake. If the amount seems worth the time and effort to you, then you should at least investigate the possibility of filing a lawsuit. Consult with attorneys who specialize in Social Security appeals.

While you may want to get legal assistance at some earlier stage of the appeal process, you certainly need expert legal assistance to file a lawsuit in federal court. Your odds of winning there depend almost entirely on convincing a court that the administrative law judge who heard your appeal made a mistake in interpreting the Social Security law. Simply asking a court to take another look at the facts of your case is almost never enough to win a federal lawsuit.

The main things to weigh in deciding whether to file a lawsuit are your chances of winning (as explained to you by an attorney specializing in such cases), the money it will cost you to fight the legal battle, and the amount of money in benefits that you stand to gain. If you balance all these things and it still seems like a good idea to go ahead with the lawsuit, then consider hiring an attorney to help you proceed.

E. Lawyers and Other Assistance

Under Social Security rules, you have a right to be represented at every stage of the appeal process by someone who understands the Social Security rules. This person may be a lawyer who specializes in Social Security matters, a nonlawyer from one of the many organizations that help people with Social Security claims, or a family member or friend who may be better than you are at organizing documents, writing letters, or speaking.

I. Deciding Whether You Need Assistance

It is not usually necessary to get assistance in preparing or presenting your appeal at the reconsideration stage. After reconsideration, however, and particularly if your appeal involves medical issues, it is often wise to seek assistance. This assistance can take several forms: talking over your appeal with a knowledgeable friend or relative; having a person who specializes in Social Security problems go over your papers with you, make suggestions, and assist you at hearings; or having a lawyer or other specialist prepare and present the appeal on your behalf.

Deciding whether to hire a lawyer or to seek an experienced nonlawyer representative depends on several things, such as:

- The complexities of your case. The more complicated the issues—particularly those involving a physical or emotional condition as it relates to qualification for disability benefits—the more likely that you need expert help.
- How much money is at stake. For example, if your appeal is only about whether your disability began in March or April, it is probably not worth hiring an attorney to represent you. The most you stand to win or lose is one month's benefits. On the other hand, if your benefits have been reduced significantly or denied entirely, it may well be worth the money to hire an attorney.
- How comfortable you feel handling the matter yourself. Particularly in the reconsideration stage of the appeal process, many people feel confident obtaining their own records and documents and discussing their claim with a local Social Security office worker. However, many other people are uncomfortable about explaining things convincingly, and so would like assistance even at this early stage. And most people become uncomfortable at the prospect of an administrative hearing, because they have never been through such a procedure before. If so, it is a good idea at least to get some advice, and perhaps representation, before this stage of the appeal process.

What a Representative Can Do to Help

If you decide to have someone represent you during the course of your appeal—either a lawyer or other specialist—he or she can handle as much or as little of the process as you want. A representative can:

- look at and copy information from your Social Security file
- file a request for reconsideration, hearing, or Appeals Council review, and schedule or reschedule hearings
- provide Social Security with information on your behalf
- accompany you, or appear instead of you, and speak on your behalf at any interview, conference, or hearing, and
- receive copies of any written decisions or other notices sent by Social Security.

2. Where to Find Assistance

Assistance with Social Security or SSI appeals can come from a lawyer or from another type of specialist who is experienced in Social Security matters. Nonlawyers who are experienced in Social Security matters frequently offer their assistance free or for a nominal charge. (See Section 2a, below, for details.) Although lawyers charge for their services, those fees are kept low by laws which restrict how much they can be paid for representing people in Social Security matters. (See Section 2b, below, for details.)

Whether you should seek assistance from a lawyer or other specialist depends on whether one or the other is easily available to you, and with whom you are most comfortable. If you reach the stage of considering going to federal court, however, you should consult with an attorney who is experienced in similar cases.



Appointment of a representative must be in writing. Once a person has agreed to become your representative for the appeal, you must give his or her name on a Social Security form entitled *Appointment of Representative (SSA-1696)*. If the representative is not a lawyer, he or she also has to sign the form, agreeing to serve as your representative. If your representative is a lawyer, he or she needs only to be named on the form. The form is available online (www.socialsecurity.gov) or at your local Social Security office, which is also where the completed form is to be filed.

a. Hiring Specialists Other Than Lawyers

The first place to inquire about assistance with your Social Security appeal may be Social Security itself. Every written notice denying a claim is accompanied by a written list of local community groups and legal services organizations—such as disability rights groups, legal aid offices, and senior counseling services—that either assist with appeals or refer claimants to appeal representatives.

The fact that you find someone through one of these groups or organizations does not guarantee that you will want that person to represent you; that will depend on how well you and the person communicate and whether you feel confident in his or her advice. But finding someone to assist or represent you through one of these organizations at least assures you that the person has experience in Social Security appeals and has backing from a legitimate organization.

Senior centers are good resources, too. Many have regularly scheduled sessions during which trained advocates can give you advice on your Social Security problems. Whether or not a particular senior center has such a program, it can usually refer you to a Social Security advocacy group whose members are trained to assist in Social Security matters. You can usually make use of these referrals if you have a disability claim, even if you are not a senior citizen.

Each state has its own agency or department handling problems of older people, including Social Security disputes. They are referred to, variously, as the Office, Department, Bureau, Division, Agency, Commission, Council, Administration, or Center on Aging. In most cases, this state agency will be able to refer you to some place near your home that offers assistance in preparing and presenting Social Security appeals. Call your state's agency and explain what you are looking for.

Other sources of assistance with Social Security matters are religious and social groups, business and fraternal associations, and unions. If you belong to such a group, it may have a referral service that can put you in touch with Social Security advocates.

Although many nonlawyer assistants and representatives provide free services, some charge a nominal fee and a few charge a substantial fee (although the amount is limited by Social Security rules). The time to ask about fees is before you hire someone to assist or represent you. Get any fee agreement in writing.

b. Hiring Lawyers

If your income is low, a lawyer may be available to assist or represent you through a “legal services” organization that has specialists in Social Security appeals. These are nonprofit organizations that seek funding from outside sources in order to serve low-income people. Legal services offices provide advice and representation for little or no money. The first place to look for legal services offices is on the list of references provided by Social Security along with its notice denying your claim. You can also find legal services offices—sometimes listed as Legal Aid—in the white pages of your telephone directory.

Beware, however, that in the steady campaign by the federal government over the past 20 years to slash public services for low-income people, many legal services offices have suffered staff cutbacks or have been eliminated altogether. So it may not be easy to find a legal aid lawyer who can help you with your appeal.

You may also find an attorney in private practice. Be aware, though, that most private lawyers know very little about Social Security; you need to find one who specializes in Social Security claims. The Social Security referral list will either give you the names of local attorneys who specialize in Social Security appeals or give

you the name of an organization that gives referrals to such private attorneys.

Your local county bar association will also have a reference list of lawyers who specialize in Social Security appeals. And while, in general, these bar association referral lists do not always include the best lawyers, in Social Security appeal matters they usually do have the best people. That is because very few lawyers specialize in Social Security appeals, and the few who are expert in the field usually list themselves with the bar association.

Normally, lawyers cost a lot of money. However, Social Security rules strictly limit the amount of money a lawyer or anyone else can charge for a Social Security appeal, which may explain why so few lawyers specialize in the field.

3. Legal Limits on Lawyers’ Fees

Whether your representative is a lawyer or other specialist, Social Security rules limit the fees he or she can charge. And not only are fees limited, but they must be approved by Social Security in each individual case.

a. Fee Agreements

Many lawyers and some nonlawyers charge a fee only if, with their help, you win your appeal. If you win your appeal at any stage of the process, you will be entitled to benefits from the date you

first applied for them—referred to as past due benefits. The lawyers take their fees as a percentage of your past due benefits. Social Security rules say that a lawyer or other representative can take as a fee 25% of your past due benefits, or \$4,000—whichever is less. If the lawyer pursues a lawsuit for you in federal court, the court will allow attorney fees of 25% of all past due benefits, without the \$4,000 maximum.

Get It in Writing

If you come to a fee arrangement with your lawyer or other representative, the representative must put it in writing, you both must sign it, and the representative must submit it to Social Security for approval. This can be done at any time before your claim is approved.

Once the fee agreement is approved, the lawyer or other representative cannot charge you any more than the amount approved, except for out-of-pocket expenses incurred during the course of your appeal—for example, transportation, the cost of getting copies of medical records, or long-distance phone calls to former employers or medical providers.

b. Fee Petitions

Some lawyers will not take on a Social Security appeal case unless you agree to pay them something regardless of whether your case is won or lost (as opposed to on a contingency fee basis, where the lawyer gets a percentage of your winnings). Social Security has the power to limit how much you are made to pay, however. If you agree to hire a lawyer under such a fee-for-service arrangement, the lawyer can't collect from you until after he or she has submitted a kind of bill called a "fee petition" to Social Security for approval.

The petition is filed when the appeal is finished, and lists in detail each service the lawyer provided for your appeal and the amount of time the lawyer spent on each such service. The lawyer must provide you with a copy of the petition. If you disagree with any of the information on the petition, you must notify your local Social Security office within 20 days of the date you receive it.

Social Security will examine the petition and determine a reasonable fee for the lawyer's services. The fee almost never exceeds 25% of what your past due benefits are if your appeal succeeds, or 25% of what those benefits would have been if your appeal does not succeed.

Social Security will send you a written notice of the amount it has approved under the fee petition. The lawyer or other representative cannot charge you any more than the fee Social Security decides on, except for out-of-pocket expenses incurred during your appeal (such as costs for photocopying, phone calls, postage, and transportation to and from your hearings).





Federal Civil Service Retirement Benefits

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More than three million people are employed by federal government agencies and departments; millions more have previously been employed there. And while the salaries of these government jobs are not always as high as those in the private sector, a comprehensive retirement system is one of the benefits that makes federal government employment attractive.

This chapter discusses the two different federal retirement systems—the Civil Service Retirement System and the Federal Employees’ Retirement System—and explains the benefits available under each.



For information about nongovernment, personal retirement plans: See *IRAs, 401(k)s & Other Retirement Plans: Taking Your Money Out*, by Twila Slesnick and John Suttle (Nolo).

Employees of State and Local Governments

Each state government has its own retirement system for its employees, and there are more than 6,000 local government retirement systems, called Public Agency Retirement Systems (PARS). It isn’t possible here to discuss the rules of all these plans, but most of them work very much like the federal government’s Civil Service Retirement System (CSRS), described in this chapter.

The amount of the pension to which an employee may be entitled is based not on total payroll contributions, as with the Social Security system, but on the highest average salary the employee reached and the number of years of employment. The age at which the employee can claim retirement benefits also depends on the number of years of employment.

As of July 1, 1991, work by employees of state or local governments who are not covered by an employer pension plan is covered by Social Security. These are usually part-time, temporary, or probationary workers.

To find out what retirement plan covers your work for a state or local government agency and to determine the rules of that plan, contact your personnel or retirement plan office, or the pension office of the public employees’ union if you belong to one.

On request, the pension office should provide you with an estimate of how much your pension benefits would be if you claimed those benefits at the various retirement ages permitted by the plan.

A. Two Retirement Systems: CSRS and FERS

There are two entirely separate retirement systems for federal workers, depending on the date the worker was first hired. Until 1984, all federal government workers were part of the Civil Service Retirement System, or CSRS. Workers covered by the CSRS receive Social Security coverage; the CSRS provides the only benefits those workers will receive for their years of federal government employment.

All federal workers hired from January 1, 1984 on were made part of a different plan called the Federal Employees' Retirement System, or FERS. Workers hired by the federal government after January 1, 1984 are also covered by Social Security, which means that work for the government simultaneously builds toward both FERS and Social Security benefits.

Employees who were already working for the federal government on January 1, 1984 were given a choice. They could either remain in the CSRS or switch over to the FERS. For those who switched, their years of employment under the CSRS were credited to the FERS.

The rules for both systems are quite similar, and both are administered by the federal government's Office of Personnel Management (OPM). Both the CSRS and the FERS are funded by a combination of automatic payroll deductions from federal employees and by contributions made by the employing agencies.

Under both systems, an employee can receive benefits if disabled, take early retirement, provide for a survivor, take a lump sum retirement amount instead of monthly benefits, and participate in a special savings program called the Thrift Savings Plan.

However, eligibility and benefit amounts are determined in a very different way than under the Social Security system. In particular, benefits are based on the highest average salary for any three years of employment, but do not depend on the total amount contributed in payroll deductions. And while benefits may be paid to retirees and to survivors, they are not increased if the retiree has dependents.

B. Retirement Benefits

The CSRS and FERS offer retirement benefits that are easy to qualify for and that can be paid out in any one of several ways. Both programs also permit retirement benefits to be structured to provide for a survivor after the retired worker has died. And both offer a special savings plan that provides tax benefits and, in the case of the FERS, includes contributions by the government.

**If You've Left Federal Work,
Then Returned**

Some people worked for the federal government before 1984—when the CSRS was their only option for retirement benefits—then left their jobs and rejoined the federal government after 1984. Those people may be entitled to retirement benefits under both systems.

If you worked for the federal government for at least five years but left that job before 1984, you may return to the CSRS if you start a new job with the federal government after January 1, 1984. If you do not choose to reenter the CSRS, you will work under the FERS, and you may qualify for retirement benefits under both the CSRS and the FERS once you have more than five years of employment under each system.

If you were out of federal employment for at least a year and you choose to reenter CSRS, you will also be covered by the Social Security system, as are FERS employees. However, once you collect both Social Security benefits and a CSRS retirement annuity, your CSRS payment will be reduced by the amount of your Social Security benefits attributable to your federal government employment.

This prevents double payment, since most CSRS recipients do not receive Social Security benefits from their federal employment, and the amount of CSRS benefits is calculated as if there were no additional retirement money from Social Security.

I. Who Is Eligible

If you have worked at least five years for the federal government as a civilian employee, you can qualify for a pension, referred to as a retirement annuity. In addition, you can get retirement credit for any years of military service after 1956 if you pay a premium based on the amount of your military pay. However, you cannot get credit for military service if you are collecting a military retirement pension.

There are two types of retirement annuity under the CSRS and FERS: an immediate annuity and a deferred annuity.

a. Immediate Annuity

You can retire at age 62 and immediately begin receiving an annuity if you worked for the federal government a total of five years. The years do not have to be consecutive, nor do they have to be for the same federal agency or department. Any combination of jobs totaling five years of work will qualify you.

If you have 20 years of service with the federal government, you can claim your immediate annuity at age 60.

With 30 years of service, a CSRS-covered worker can retire with a pension at age 55. A worker covered by FERS with 30 years of service can retire with a pension at what is called the minimum retirement age (MRA). Your MRA depends on the year you were born. For people born before 1948, it is 55. For those born in 1948 and after, see the chart below.

Minimum Retirement Age (MRA) by Year of Birth

The following chart tells you when you reach your MRA, depending on the year you were born.

Birth Year	MRA
Before 1948	55
1948	55 + 2 months
1949	55 + 4 months
1950	55 + 6 months
1951	55 + 8 months
1952	55 + 10 months
1953-64	56
1965	56 + 2 months
1966	56 + 4 months
1967	56 + 6 months
1968	56 + 8 months
1969	56 + 10 months
1970 & after	57

If You Are Laid Off Before Becoming Eligible for Your Pension

CSRS and FERS rules allow some long-term workers to collect an immediate annuity even though they have been laid off from their jobs before reaching the normal eligibility age.

Under CSRS, a worker who has been employed for at least one year in the two years immediately before being laid off, and who is age 50 with 20 years of service or any age with 25 years of service, may be eligible for an immediate annuity. Under FERS, the eligibility for this immediate annuity is the same, except that you need not have been employed within the past two years. The amount of the immediate annuity is reduced from its full amount by 2% per year for every year you are under age 55 when claiming this immediate annuity.

There are two circumstances in which you may not be entitled to an immediate annuity after losing your job. The first is if you have been fired for cause: misconduct, delinquency, or poor job performance. The second is if you have been offered another job in the same agency, in the same geographic area, which is not more than two grades or pay levels below the current job, but you refuse to take it.



Special rules apply to law enforcement personnel, firefighters, and air traffic controllers.

Recognizing the high stress of these jobs, the CSRS system has set early retirement years and lower requirements for years of service. If you have been a law enforcement officer or firefighter under the CSRS, you can claim retirement benefits at age 50 with 20 years of service. If you have been an air traffic controller, you may be able to retire at age 50 with 20 years of employment, or at any age once you have 25 years of service.

b. Deferred Annuity

If you end your federal employment before retirement age, you have a choice of leaving your payroll contributions in the CSRS or FERS, or withdrawing them in a lump sum when you leave employment. If you leave the contributions in the system when you end your federal job, you can claim a retirement annuity at age 62. If you leave the money in the retirement system but later decide you want it without waiting for retirement, you can collect it in a lump sum at any time before you reach age 62.

If you switch jobs, then depending on the amount of your salary and your years of service with the government, it may be to your benefit to leave your money in the retirement system. The amount of your federal retirement annuity would be based on your length of service and the highest levels of pay you received. (See Section 2, below, regarding benefits calculations.)

If you have worked for a long time and have reached a relatively high salary, you will be eli-

gible for a high pension when you reach age 62. That pension will probably amount to much more money than the lump sum you could withdraw when leaving your federal job.

Before deciding which course of action to take, find out from the OPM exactly how much your lump sum withdrawal would be, and get an estimate of what your annuity would be at age 62. Of course, your decision will also depend on how badly you need the cash immediately upon leaving your federal job.

Example: Kazuo worked for the federal government from 1965 through 1992. In 1984, he decided to remain in the CSRS rather than switch to the FERS. By the time he left his government job, he had contributed over \$10,000 to the CSRS retirement fund. Kazuo moved to another job outside the government, and did not immediately need the money in his retirement fund, so he left his contributions in the CSRS.

When Kazuo turns 62, he could collect a deferred annuity, which would then add to his monthly income from his job, or to Social Security retirement benefits if he had qualified for them by working long enough in the private sector both before and after his government job.

Example: Angela worked for the federal government from 1975 through 1995. In 1984, she switched her pension coverage from the CSRS to the FERS. By the time she left her job, she had contributed almost \$8,000 to the retirement fund. When Angela left the federal government, she did not immediately need the money in her retirement fund, so she left her contributions in the FERS.

When she turns 62, she can collect her FERS deferred annuity, in addition to whatever she is

making on a nonfederal job, or to Social Security retirement benefits that she also earned from her years of FERS-covered government employment.

2. Calculating Benefits

Two factors are used to figure the amount of your federal CSRS or FERS retirement annuity.

The first factor is the number of years you have been employed by the federal government, contributing to the retirement fund. This can include years of military service if you also have at least five years of civilian service (unless you are receiving a military retirement pension).

The second factor used to determine the amount of your annuity is what the retirement program refers to as your “high-three average salary”—your average salary for the three consecutive years in which you have had your highest earnings. For example, if in three successive years you reached \$35,000, \$35,000, and \$38,000, you would add these together and divide the total by three. (The total would be \$108,000, which divided by three equals a high-three average of \$36,000.)

Both CSRS and FERS base the retirement annuity on the high-three average, but each computes the resulting benefit differently.



You'll get a cost-of-living increase. Both CSRS and FERS benefits are increased annually to keep pace with the rising cost-of-living. As with Social Security benefits, these cost-of-living increases are tied to the rise in the Consumer Price Index, a yearly indicator of the cost of goods and services.



You can get benefit estimates online. The Office of Personnel Management (OPM), which operates the CSRS and FERS systems, now offers a website with a calculator that will estimate your federal civil service retirement benefits. Go to www.seniors.gov and click “Federal Employees Retirement Calculator.” The calculator can estimate what your normal, early, or disability retirement benefits are likely to be. However, the accuracy of the estimate depends greatly on how near you are to claiming your benefits—the nearer you are, the more accurate the estimate.

a. CSRS Benefits

Once your high-three average is calculated, CSRS computes your pension benefits by adding:

- 1.5% of your high-three average pay, multiplied by your first five years of service, plus
- 1.75% of your high-three average pay, multiplied by the number of your years of employment over five, up to ten, plus

- 2% of your high-three average pay, multiplied by the number of years of service over ten.

Example: John put in 25 years working for a federal government agency. His highest three consecutive years of pay were \$28,000, \$30,000, and \$32,000. That makes his high-three average pay \$30,000. After 25 years, John's retirement pension would be figured like this:

- 1.5% of the \$30,000 average is \$450; that \$450 is multiplied by the first five years of service, for a total for the first five years of service of \$2,250; plus
- 1.75% of the \$30,000 average is \$525; that \$525 is multiplied by the second five years of service, for a total for the second five years of service of \$2,625; plus
- 2% of the \$30,000 is \$600; that \$600 is multiplied by the remaining 15 years of service, for a total for the last 15 years of service of \$9,000.

Together, the three parts of John's pension would add up to a yearly benefit of \$13,875.



Some workers will receive separate CSRS and FERS benefits. If you had years of service under the CSRS, left that job, and later returned to work for the federal government under the FERS, you will receive two separate annuities, one using your high-three earnings under CSRS and the other your high-three earnings under FERS. (See Section A, above.)

CSRS Benefits and Social Security

If your federal employment is covered by CSRS, it is not also covered by the Social Security system. However, most people who worked for the federal government under CSRS have also worked, or will work, at some other jobs during their lifetimes. If that other work is covered by Social Security and you have enough work credits to qualify for Social Security retirement benefits, you can collect both your retirement benefits and your CSRS annuity.

If you receive a CSRS pension and also Social Security dependents or survivors benefits based on your spouse's work record—rather than Social Security retirement benefits based on your own work record—those benefits will be severely reduced. This is known as the pension offset rule. (See Chapter 4, Section E, and Chapter 5, Section F, for further description.) If you are receiving a CSRS annuity as the survivor of a CSRS worker, this rule does not apply.

b. FERS Benefits

FERS has several different types of retirement benefits: full benefits, reduced early retirement benefits, deferred benefits for people who left their federal jobs before retiring, and a supplement for longtime employees.

Full retirement annuity. Full FERS pension benefits are figured by taking 1% of the high-three average and multiplying it by the number of your years of service.

Example: Elvira worked 25 years for the federal government, switching to FERS in 1984. Her highest three consecutive years of pay were \$38,000, \$40,000, and \$42,000. That makes her high-three average pay \$40,000. Elvira's retirement pension would be figured like this: 1% of \$40,000 = \$400; \$400 x 25 (years of service) = \$10,000, which would be her yearly pension annuity. And under FERS, Elvira would also collect Social Security retirement benefits as soon as she reaches an eligible age.

Reduced benefits for early retirement. If you have accumulated enough years of service under the FERS, you can take early retirement with lower benefits. With ten years of service, you can take early retirement at the minimum retirement age (MRA). (See chart in Section 1, above.) Your benefits will be reduced from the full retirement amount by 5% for each year under age 62 at which you claim retirement.

Deferred benefits if you leave. If you leave your federal job after at least five years of service but before reaching retirement status, you can claim retirement benefits when you reach a certain retirement age, which depends on your years of service. With five years of service, you can claim retirement benefits at age 62. With ten years or more, you can claim retirement at the minimum retirement age, currently 55, but the benefit will be reduced by 5% per year for every year earlier than age 62 at which you claim benefits.



Reduced benefits may make financial sense.

Although your deferred retirement benefits will be reduced 5% for every year under age 62 at which you claim them, it may still be to your advantage to claim as early as age 55. Since you are not adding any more years of service and your high-three salary remains the same, the base amount of your benefit will be the same whenever you take it. The 5% per year reduction may be offset by the cost-of-living increases you will receive each year, plus interest you can get by investing the money.

Annuity supplement for long-term employees.

A special supplement to the retirement annuity is available at age 55 to people with 30 years' service, at age 60 with 20 years' service. The supplemental amount is based on total earnings and years of service, and is figured using a complex set of calculations. To determine how much your annuity supplement would be, contact the OPM office at the agency where you work.



Your supplement may be reduced by your earnings.

Unlike the standard FERS annuity, if you are under age 62, your annuity supplement is reduced by \$1 for every \$2 over a certain yearly amount in earnings from other employment after you retire from federal government work. This earnings limit rule works the same as the earnings limit for Social Security benefits. (See Chapter 2, Section D, for a description.)

3. Survivors Benefits

Unlike Social Security retirement benefits, the surviving spouse or other survivor of a federal CSRS retiree does not necessarily receive survivors benefits after the retiree dies. To plan ahead for this, the federal worker is given several choices at retirement.

The retiring worker can choose to:

- take a full retirement annuity—if so, no benefits will be paid to any survivors after the retiree dies (detailed in Subsection a, below)
- elect a full survivor benefit for a current spouse, in which case the retiree's own annuity will be less (see Subsection b, below)
- elect to have survivor benefits paid to someone other than a current spouse (which would also reduce the retiree's own annuity, as covered in Subsection c, below), or
- choose to provide a reduced survivor benefit, which means his or her own annuity will be lower than a full retirement annuity but higher than if a full survivor annuity were provided (see Subsection d, below).

a. Annuity Without Survivor Benefits

At retirement, a CSRS or FERS employee can choose to take full retirement benefits without any provision for survivors. This makes particular sense if the retiree is unmarried and has no one else depending on him or her for financial support. It also makes good sense if the retiree, or retiree and spouse, have extremely limited income and immediately need the full retire-

ment annuity to get by. Finally, it is a wise choice if the retired worker is married but his or her spouse is not likely to outlive the worker.

A worker who is married at retirement must specifically choose this no-survivor-benefit option by filing a form with the Office of Personnel Management (OPM). The worker's spouse must sign and notarize this form, which acknowledges that the retiree has given up the right to a survivor annuity. If the spouse's whereabouts are unknown, or the spouse is unable to understand the waiver and knowingly sign the form, a petition can be filed with the OPM to waive the requirement of a written consent form.

b. Annuity With Full Spousal Survivor Benefits

If you are married when you retire from federal employment, and you and your spouse do not waive your right to a survivor annuity, your retirement annuity will be reduced slightly to provide a lifetime annuity for your spouse if you die first.

This full survivor annuity can also be provided for a former spouse, although if the worker has remarried, the current spouse must consent. A survivor benefit ends when the surviving spouse dies, or when the surviving spouse remarries before age 55. After age 55, the surviving spouse is free to remarry without losing the survivor annuity.

The amount of full survivor annuity is slightly different for CSRS and FERS employees.

CSRS full survivor benefits. A CSRS retirement annuity is reduced, to provide full survivor benefits, by 2.5% of the first \$3,600 per year, plus 10% of any amount over \$3,600. The surviving spouse's annuity will be 55% of the full retirement annuity—that is, 55% of the amount before the 2.5% and 10% reductions are taken. And the 55% will include any yearly cost-of-living raises the retiree has received since the pension began.

Example: Ethel is eligible to receive a pension of \$9,250 a year. She provides a full survivor benefit for Dante, her husband, so her own retirement annuity is reduced.

The first \$3,600 is reduced by 2.5%, which means Ethel receives \$3,510 of that first \$3,600. The remaining \$5,650 is reduced by 10%, leaving \$5,085. Ethel's total pension is \$8,595 a year instead of \$9,250, a reduction of \$655 a year. For that reduction, Dante is entitled (if Ethel dies) to a surviving spouse's pension of 55% of the original \$9,250, which works out to \$5,087.50 a year.

FERS full survivor benefits. A FERS full retirement pension is reduced by 10% to provide an annuity for the surviving spouse. The surviving spouse's annuity will be 50% of the retiree's full pension amount—that is, 50% of the amount before the 10% reduction.

A retiring FERS worker can also choose a 5% reduction in his or her annuity, which will provide for a 25% annuity for a survivor. The survivor annuity will include any yearly cost-of-living raises the retiree receives after the pension begins.

Example: Rigoberto is eligible to receive a pension of \$12,000 a year. He provides for a full survivor benefit for Doris, his wife, reducing his own retirement annuity by 10%, or \$1,200. So instead of \$12,000 per year, Rigoberto receives \$10,800—\$12,000 minus the \$1,200 reduction. In exchange for that reduction, Doris will be entitled, upon Rigoberto's death, to receive a surviving spouse's pension of 50% of the original \$12,000, which works out to \$6,000 a year.

c. Survivor Annuity to Other Than Spouse

Both the CSRS and FERS provide for a 55% survivor annuity that can be paid to a person other than a current spouse. The amount your own retirement annuity is reduced to pay for this annuity depends on the difference in age between you and the named beneficiary.

If the beneficiary you name is older than you or no more than five years younger than you, your annuity will be reduced by 10%. Your annuity is reduced 5% for every additional five years the beneficiary is younger than you—15% reduced if five to ten years younger, 20% if ten to 15 years younger, and so on.

If the person you name as beneficiary dies before you do, you can have your own annuity restored to the full amount for the rest of your life by simply notifying the OPM. Once you have chosen to name a beneficiary, however, you cannot change your mind and restore yourself to a full pension as long as that person lives.

d. Reduced Survivor Benefits

Both CSRS and FERS rules allow a retiring employee to divide up his or her annuity, taking the full amount of one part and using the rest to set up a survivor annuity. You can split up your annuity into survivor and nonsurvivor parts in any proportions you want.

For example, if you are entitled to a \$10,000-per-year annuity, you can choose to keep \$5,000 as fully your own and direct that the other \$5,000 be allotted to and reduced for a survivor benefit. That second \$5,000 would be reduced by the normal survivor percentages—2.5% of the first \$3,600, and 10% of the remaining \$1,400—leaving you \$4,770 plus the untouched \$5,000. This arrangement would provide a survivor with 55% of the \$5,000 you assigned to the survivor annuity, which amounts to a yearly benefit of \$2,750 after your death.

Deciding Whether to Reduce Your Annuity

No obvious answer exists regarding whether to take a reduced pension to provide for another person. Each retiree and spouse, or other person who would be named as beneficiary, must decide for themselves. It will help to consider:

Age. If your spouse or other potential beneficiary is considerably younger than you are and likely to outlive you by many years, taking a reduced pension now probably makes good sense. The 55% pension could go for many years to your beneficiary. On the other hand, if your beneficiary is considerably older than you are, there may be little advantage to reducing your own immediate pension.

Health. If you are in poor health and may not survive for many years, then it is probably more important to provide a survivor annuity. Conversely, if your beneficiary is in poor health and not likely to survive you, it is probably better to take your full pension.

Income. If your spouse or other beneficiary has or will have a substantial retirement pension or other income of his or her own, there is less need to reduce your own pension to protect your beneficiary. On the other hand, if your beneficiary is working now and earning a salary that will enable you to afford taking a reduced pension, that will permit your beneficiary to count on a survivor annuity after you are gone.

4. Thrift Savings Plan

In addition to the annuity pension plan to which both the employee and the employer contribute, the federal employee has the opportunity to build up tax-deferred retirement savings through the Thrift Savings Plan (TSP). The TSP is similar to 401(k) savings plans made available to some employees in the private sector.

a. Contributions to TSP Account

The TSP for a CSRS worker is funded solely by the worker; it is a savings account of the worker's own money, which defers tax liability until retirement. For FERS employees, the government also contributes to TSP accounts, so that the TSP is both a tax-deferring savings plan and an additional pension.

CSRS contributions. CSRS-covered workers may put up to 5% of their before-tax wages into a TSP savings account. They pay no income tax on the income, or on interest earned, if they leave the money in the account until retiring from federal service with a CSRS annuity.

FERS contributions. The government automatically contributes an amount equal to 1% of an employee's pay into a TSP account for the employee. A worker who is covered by FERS may also put up to 10% of his or her pretax wages into the TSP savings account. If so, the government will match some of the amounts an employee puts in, in addition to its automatic 1% contribution.

The government matches dollar for dollar the first 3% of wages that an employee puts in the

TSP account, and matches 50 cents per dollar for the next 2% of pay the employee puts in the TSP account. If the employee leaves the money in the account until retiring from federal service, he or she won't owe any tax on the money put into the account or on the interest earned until the money is withdrawn at retirement.

b. Withdrawal From TSP Account

When an employee retires from federal service with either a deferred or immediate annuity, the employee may take out his or her TSP money in a lump sum or in payments of equal amounts over time. The employee will owe income tax when the amounts are withdrawn. But a person who is no longer working full time is likely to be in a lower individual income tax bracket and so will owe less in taxes.

The retiring employee also has the option to transfer the money to an Individual Retirement Account (IRA), which continues the money's tax-deferred status. The retiring employee may also use the TSP account funds to purchase an annuity, which is a plan that pays a set amount for life to the retired worker. Some annuities also permit additional payments to the spouse of a retired worker after the worker dies.

An employee who leaves federal service and withdraws the TSP money before being eligible for a retirement annuity will owe a 10% penalty tax on the money in the account. However, the employee has the option of transferring, or rolling over, the money in the TSP account to a nongovernment Individual Retirement Account (IRA), which will maintain the same tax-exempt status, and avoids the tax penalty. The normal

limit on yearly contributions to an IRA account does not apply to this one-time transfer of TSP funds.



You'll be penalized for working after age 70.

If you continue to work for the federal government after you reach age 70, you are not permitted to keep the full tax-deferred amounts in your TSP account. Internal Revenue Service rules require that you begin withdrawing certain minimum amounts from the account at that age. See the personnel administrator where you work to find out the details of this minimum required withdrawal.

C. Disability Benefits to Federal Workers

Both the CSRS and FERS provide benefits for employees who become disabled while working for the government.

I. Who Is Eligible

If you have worked for the federal government for five years or more under CSRS, you may be eligible for benefits if you become disabled before you reach retirement age. If you are covered by FERS, you need to have been employed for only 18 months.

2. Definition of Disability

Under both CSRS and FERS rules, you are considered disabled if, because of disease or injury, you are unable to perform your job. In deciding whether a worker is disabled, the OPM determines whether:

- the employee can perform useful and efficient service in the specific job
- every reasonable effort to preserve the person's employment, such as making physical modifications to the jobsite, has failed, and
- there is no other vacant position in the same government agency and geographic area and at the same civil service grade or class as the current job that the employee could perform.

It is somewhat easier to qualify for federal civil service disability than for Social Security disability benefits. Under federal civil service rules, you don't have to be so disabled that you are unable to do any sort of paid work. Instead, you can qualify for disability benefits merely because you are unable to work in the same government agency where you already work, doing a vacant job there, at the level you had attained when you became disabled. It doesn't matter that you might be able to work at some other job at a different level or outside the government agency.

Proof of disability depends on information from two separate but equally important sources. First, your physician must write a letter to the OPM fully describing your disability and the date it began, and explain why he or she believes you are unable to perform your job effectively. You can assist your doctor by carefully explaining what your job entails and why your disability prevents you from performing it.

The second source of information is your supervisor at work. He or she must give OPM a written statement explaining your duties at work, how your disability impairs your job performance, and whether any other job of comparable rank and pay is available to you. You can help yourself and your supervisor by pointing out the specific ways in which your disability interferes with your job and by noting when your disability began to make efficient work impossible.

3. Review of Disability Status

Your disability does not have to be permanent for you to receive federal employees' disability benefits. But the government, at its expense, will periodically require that you be examined by a physician to determine whether or not you continue to be disabled.

As with your original claim for disability benefits, it will be helpful if your own physician can write a letter detailing the specific ways in which your condition continues to be disabling. The letter will assist the government's doctor—who will probably only see you once, for a brief examination—in understanding why you are still disabled. The best approach is to have your own doctor write to the government doctor directly, so that the explanation of your condition and its limitations will already be in his or her file when you undergo your examination.

If your disability is found to be permanent, or if you reach age 60 without recovering from the disability, you will receive permanent disability retirement benefits. You will not be subjected to any further government examinations, and you will receive your disability benefits for

life unless you are later considered to have recovered.

You are officially considered recovered if:

- you voluntarily take any new job with the federal government
- your yearly earnings at jobs or self-employment outside the federal government reach 80% of the current pay for your previous government job, or
- a medical examination determines you are physically able to perform your job.

If any of these types of recovery occur, your disability payments will end either:

- on the date you begin reemployment with the government
- six months from the end of the year in which you earn 80% of your prior salary, or
- one year from the date of the medical exam that determined you had physically recovered.

4. Amount of Benefits

The amount of disability benefits is figured differently by the CSRS and the FERS.

a. CSRS Disability Benefit Amounts

CSRS disability benefits are the lower of either:

- 40% of your high-three average pay (defined in Section B2, above), or
- a portion of the regular pension you would have received if you had worked until age 60. This pension figure is computed by adding

together your years of service plus the number of years remaining until you reach age 60. Depending on this total, your high-three average salary is multiplied by a certain percentage—slightly more than 16% for ten years total; slightly over 26% for 15 years; slightly over 36% for 20 years; 40% for 22 years or more—to arrive at the disability benefits figure.

Example: Henry went on disability at age 55, after ten years of employment during which he had reached a high-three average pay of \$34,000; 40% of his high-three pay would be \$14,400. Using the alternate method of computation, the number of years remaining until he reached age 60 is five, which would be added to his number of years of employment for a total of 15 years. At 15 years, the high-three average salary is multiplied by just over 26%, for a total of \$8,925. Since Henry is entitled only to the lower of the two computations, he would receive \$8,925 per year in benefits.

Example: Alice went on disability at age 50, with 15 years of service. Her high-three average salary was \$38,000. She had ten years until she reached age 60, which were added to her 15 years of service for a total of 25 years. Because this is more than 22 years, her yearly disability benefit would be 40% of her high-three average salary—which is the same figure as the alternate method of computing benefits—amounting to \$15,200.

b. FERS Disability Benefit Amounts

Benefit amounts under FERS change over time. In the first year after disability, the disabled worker receives 60% of the high-three average

pay, reduced by any Social Security disability benefits he or she may be receiving.

From the second year of FERS disability until age 62, the worker receives 40% of high-three salary, minus 60% of any Social Security disability benefits. These benefits are increased yearly, based on a cost-of-living formula that is 1% lower than the rise in the Consumer Price Index.

At age 62, FERS computes what the disabled worker's retirement annuity would have been had he or she worked until reaching age 62. A benefit figure is determined by taking 1% of the total number of years of employment plus the number of years on disability up to age 62, and multiplying that by the worker's high-three average salary plus all cost-of-living increases since going on disability. That figure will be the yearly disability benefits for the remainder of the worker's lifetime.

D. Payments to Surviving Family Members

In addition to their retirement pension programs, the CSRS and FERS provide some financial support for the family of a federal worker who dies while still employed by the government.

I. Who Is Eligible

If a federal worker covered by either CSRS or FERS dies while still employed by the government, the surviving spouse and minor children can receive survivor benefits if the worker had

been employed by the government for at least 18 months.

a. Benefits for Spouse

For the surviving spouse to collect benefits, either the couple must have been married at least a year when the worker died, or the surviving spouse must be the parent of the worker's child. The survivor benefit is paid to the surviving spouse regardless of the spouse's age.

A surviving spouse who also works for the federal government can collect both survivor benefits and his or her own retirement pension.

b. Benefits for Children

The children of a deceased federal worker also receive benefits until each reaches 18 years of age or gets married. If the child is a full-time high school or college student, benefits can continue until age 22. If a child becomes disabled before reaching age 18, the survivor benefits may continue for as long as the child is incapable of full self-support.

A child of an unmarried deceased worker also qualifies for a survivor annuity. If the unmarried worker was the father, the worker must have acknowledged the child or a court must have established paternity. A stepchild may also qualify for benefits if he or she lived with the worker in a parent-child relationship.

2. Amount of Benefits

The amount of survivor benefits depends on whether the deceased employee was covered by CSRS or FERS.

a. CSRS Benefits

If a CSRS-covered worker dies while still employed by the government, his or her surviving spouse and qualifying children will each receive an annuity.

Spouse. The surviving spouse's CSRS annuity is 55% of the retirement annuity that the worker earned before dying. The survivor is guaranteed a minimum benefit of 55% of which-ever is less, either:

- 40% of the worker's high-three average pay (see Section B, above, to calculate), or
- the amount the worker's retirement annuity would have been at age 60.

A surviving spouse loses the annuity if he or she remarries before age 55; after age 55, the annuity continues regardless of remarriage. If the second marriage ends before the surviving spouse turns 55, he or she can have the survivor annuity reinstated.

Children. The amount payable to the surviving children of a CSRS-covered worker depends on whether the other parent is still alive. Each qualifying child receives an annuity based on the following computations:

- if there is a surviving parent who was the spouse of the deceased employee, 60% of the worker's high-three average pay, divided by the number of qualified children, or approxi-

mately \$350 per month (the figure goes up slightly each year, adjusted for inflation), whichever is less

- if there is no surviving parent, 75% of the high-three average pay, divided by the number of qualified children, or approximately \$400 per month, whichever is less.

b. FERS Benefits

FERS benefits payable to a qualified surviving child are the same as for CSRS-covered employees. However, they are reduced by any Social Security survivors benefits the child receives. (See Chapter 5 regarding survivors benefits.)

The amount of benefits a surviving spouse may receive depends on the number of years the deceased worker was employed. If the worker was employed for more than 18 months but less than ten years, the surviving spouse is entitled to a lump sum payment. That payment is approximately \$22,000 (the figure goes up each year, adjusted for inflation), plus either 50% of the worker's yearly pay at the time of death, or 50% of the worker's high-three average, whichever is higher.

If the worker was employed for more than ten years, the surviving spouse also gets an annuity equal to 50% of what the employee's retirement annuity would have been.

These spouse's survivor benefits are not reduced by any Social Security survivor benefits.

E. Applying for CSRS or FERS Benefits

Decisions about both CSRS and FERS benefit claims are made by the federal government's Office of Personnel Management (OPM). You must file a written application for specific benefits. You may apply at the personnel office within the agency at which you work. If you no longer work for the agency, you may file your application at any OPM office.

You can get general information about benefits, application forms, the application process, and appeals from decisions of the OPM by telephone from the OPM's Retirement Information Office. Recorded information is available 24 hours a day at 202-606-0400. You can get answers to questions that do not depend on your personal employment records by calling 202-606-0500 or by visiting the OPM's website at www.opm.gov.

To obtain information about the benefits available to you based on your personal employment record, go in person to your agency's personnel office or put your request in writing and send it to:

U.S. Office of Personnel Management
Employee Services and Records Center
Boyers, PA 16017

This is the office where employee records are maintained, and most questions can be answered by the staff there. If there is some complicated question they cannot answer, they will forward your inquiry to the Washington office of OPM, which will respond.





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In addition to the pensions and benefits that arise from both public and private civilian employment, many older Americans may be eligible for certain benefits based on their military service.

The Department of Veterans Affairs (VA) operates a number of programs providing financial, medical, and other assistance to veterans. Eligibility may depend on financial need or time of service.

For older veterans, three major benefit programs are of particular value: disability compensation, veterans pensions, and, perhaps most significant, free or low-cost medical care through VA hospitals and medical facilities. This chapter explains some of these benefits.

A. Types of Military Service Required

Veterans benefits are available only to people who performed active service in a uniformed branch of the military: Army, Navy, Marine Corps, Air Force, Coast Guard, Women's Army Auxiliary Corps (WAAC), or Women's Air Service Pilots (WASP).

Active service is defined as either active duty or active duty for training.

I. Active Duty

Active duty means full-time service in one of the uniformed branches of the military forces mentioned above. It also includes full-time duty in the Commissioned Officer Corps of the Public Health Service or National Oceanic and Atmospheric Administration (NOAA), formerly Coast and Geodetic Survey. And under some circumstances, full-time members of the Merchant Marine who served during wartime and wartime members of the Flying Tigers may also qualify.

Any length of active duty can qualify a veteran for benefits, with the exception of pensions for financially needy veterans, which require at least 90 days of active duty service. (See Section C, below, for more on need-based pensions.)

2. Active Duty for Training

Generally, membership in the National Guard or Reserve Corps does not qualify a person for veterans benefits. However, if a person in the Guard or Reserves is called up for full-time duty in the armed forces, this period of service is called active duty for training. A person who is injured or becomes ill during that period of active duty for training may be eligible for veterans disability benefits if the injury or illness leads to a disability.

B. Compensation for Service-Connected Disability

The VA administers a system of benefits for veterans who have a disability that can be connected in any way to the period of service. More lenient than civil disability benefit programs, a veteran can receive assistance even if he or she is only partially disabled, and almost regardless of the cause, as long as it occurred while performing some duty related to service. And if your injury or illness first arose during a period of wartime, the rules for compensation are even easier to meet.

I. Who Is Eligible

Compensation is available for veterans who have a service-connected disability. Service-connected means that they were wounded, injured, or became ill—or aggravated an existing condition—while on active duty, or active duty for training, in the armed forces.

If your condition arose while you were on active duty during peacetime, your disability must have resulted directly from military duties. In reality, though, this requirement rules out only injuries sustained while on leave, for example, or while AWOL or committing some militarily punishable offense. Virtually all other activities—including playing for the base softball

team, eating in the mess, traveling to and from training, and going on authorized leave—are considered part of military duties.

The rules are even more lenient if the condition or injury occurred during time of war or national emergency, as officially designated and listed below. In such cases you may be compensated even though the injury or illness was completely unrelated to military duties, such as while on furlough or leave. These official periods of war or national emergency include:

- **World War I.** April 6, 1917 through November 11, 1918; if you had any active service during this basic period, the time is extended to July 1, 1921.
- **World War II.** December 7, 1941 through December 31, 1946.
- **Korean War.** June 27, 1950 through January 31, 1955.
- **Vietnam War.** August 5, 1964 through May 7, 1975.
- **Persian Gulf War.** August 2, 1990 through a date yet to be set by Congress or Presidential Proclamation.

Note that the periods of time considered part of the Second World War and the Korean War are longer than the time spans normally attributed to those conflicts.

Disabilities From Agent Orange, Radiation, and Gulf War Syndrome

Because of the military use of chemicals and radioactive materials, many veterans have fallen ill with serious, disabling diseases years after their service ended. But these veterans had no way to prove their disease was caused by exposure during military service. After sustained pressure from veterans groups, the VA has finally admitted that certain exposure does indeed cause specific diseases. As a result, if a veteran was exposed to Agent Orange or radiation and later is disabled by certain diseases, the disability is presumed to be service-connected. To a limited extent, the same can be said of “Gulf War Syndrome.”

Vietnam and Agent Orange: If you served in Vietnam and have become disabled by one of the following diseases, you are presumed to have contracted the disease through exposure to Agent Orange and may be eligible for service-connected disability benefits. Diseases include prostate cancer, Hodgkin’s disease, multiple myeloma, respiratory cancers (lung, bronchus, larynx, trachea), non-Hodgkin’s lymphoma, chloracne, porphyria cutanea tarda, soft-tissue sarcoma, and acute/subacute peripheral neuropathy.

Radiation exposure: If your work in the military exposed you extensively to ionizing radiation, you may be eligible for service-connected disability benefits if you have become disabled by most types of leukemia or lymphoma, most types of cancer, brain or central nervous system tumors, thyroid disease, or multiple myeloma.

Gulf War Syndrome: Almost immediately after serving in the Gulf War, many veterans complained about illnesses—joint pain, rash, fatigue, memory loss, intestinal problems—that they did not have before service in the Gulf. The cause(s) of these illnesses have not been definitively diagnosed, and the government initially went to great lengths to deny that they were caused by military service—even suggesting that they were not really illnesses at all. Slowly and grudgingly, the government is changing its tune. If symptoms of a Gulf War veteran’s undiagnosed illness appeared by December 31, 2001, that illness may now be presumed to be connected to Gulf service. And if the illness results in a persistent disability, the veteran may be eligible for service-connected disability compensation. For information about Gulf War-related illness and compensation, a veteran may call a special Gulf War Veterans Information Hotline at 800-PGW-VETS.

2. Amount of Benefits

The amount of disability compensation to which you are entitled depends on the seriousness of the disability. When you apply for disability compensation, your medical records are reviewed and VA personnel will examine you.

Your disability is given a rating, based on the extent to which it interferes with the average

person’s ability to earn a living. This rating is expressed in percent of disability—0% to 100% disabled, in increments of 10%.

Unfortunately, this rating system does not normally take into account the real effect of your disability on the work you do. Rather, it applies arbitrary percentages—20% or 30% for the loss of a finger or toe, for example—to the theoretical average person’s ability to earn a living. Obviously, the loss of a finger affects a piano player

much more than it affects an opera singer. But the VA usually applies its fixed schedule of disabilities to common injuries and diseases.

However, if your disability does not match any of the simple descriptions in the VA's rating system, the VA may consider the effect of your condition on the work you are able to do when rating your individual disability.

Benefits range from about \$100 per month for a 10% disability to about \$2,100 per month for total or 100% disability. If you have at least a 30% disability rating, your dependents are also eligible for some minimal benefits.

Eligible dependents include your spouse and your children up to age 18, or age 22 if a full-time student, or of any age if disabled. The total amount received depends on the number of dependents and on the disability rating—the higher the rating, the higher the benefits. The additional amounts for dependents range from \$35 to \$120 per month for a spouse and \$20 to \$60 per month for each child.

3. Changes to Your Rating

Although most service-connected disabilities show up during or soon after military service, some conditions may not appear, or not become disabling, until years after you get out of the service. Regardless of when a condition actually becomes disabling, if it can be traced to injury or illness that occurred while you were in the service, it can be compensated.

Example: Claudio's knee was bashed while serving as a cook at a training camp during World War II. The knee healed well and Claudio had no serious trouble with it during the war or the years immediately following it. However, as he

got older, his knee got steadily worse. His doctor diagnosed Claudio with a serious arthritic condition in the knee, a result of the wartime injury.

Because Claudio's knee condition resulted from his wartime service, he was entitled to claim disability benefits when the knee began to interfere with his normal activities, even though he made no such claim before he was discharged from the service.

Sometimes, a disability that rated low when it first appeared will grow progressively worse in later years. In such a case, a veteran can claim disability benefits even if he or she was previously rated by the VA as not disabled. Or the veteran can apply for an upgrading of an already-existing disability rating if the condition has worsened over time.

Example: Ernie was an M.P. in Japan during the Korean War. While on leave, Ernie picked up a lung infection. The scarring from it, over the years, occasionally gave him minor respiratory difficulty. A few years after his discharge, Ernie applied for a service-connected disability. Although he picked up his illness while on leave, he was eligible for benefits because he had been on active duty during wartime. He was given a 10% disability rating for his labored breathing.

As he got older, Ernie experienced more breathing difficulties, to the point that even mild exertion made his breathing painful and dangerously difficult. His doctor said that poorer circulation with age was making Ernie's lung condition worse. Since his doctor verified that his condition had worsened, Ernie could apply for an upgrading of his disability rating. The new disability rating was 40%, which meant not only that Ernie's own benefits would be higher, but that his wife was also eligible for some benefits as a qualifying dependent. (See Section 2, above, regarding dependents benefits.)

C. Pension Benefits for Financially Needy Disabled Veterans

A small monthly cash benefit is available to a financially needy wartime veteran who is 100% disabled from causes that are not service-connected. Unfortunately, the amount is usually extremely low, only enough to bring the veteran's total income from all sources to just above the poverty line.

To qualify for this small cash benefit, the veteran must have had 90 days or more of active duty, with at least one day during a period of war. (See Section B1, above, for the list of recognized periods of war.) However, there is no requirement of service in or near actual combat.

A totally disabled veteran who meets the service requirements is granted an amount that will bring his or her total annual income—including income from private pensions, Social Security, and SSI—up to minimum levels established by Congress. Those minimum levels, however, are extremely low: about \$800 per month from all sources for a veteran with no dependents, about \$1,000 per month for a veteran with one dependent—a spouse, or a child under age 18, or disabled—and slightly higher for each additional dependent.

Some veterans are entitled to a larger benefit if they live in a nursing home, are unable to leave their houses, or are in regular need of aid and attendance. Veterans with out-of-pocket medical expenses are also entitled to a larger benefit.

Limits on Assets

The pension described in this section is not intended for veterans who have savings or other assets that could be used, or be cashed in to use, for living expenses. (Fortunately, these potential living expense assets do not include the value of a home the veteran lives in.) So, even a disabled veteran with little or no income will not qualify for the pension benefits if he or she has assets over a certain limit.

The VA usually considers \$50,000 in total assets to be the limit, depending on the cost of living in the area in which the veteran lives and the amount of ongoing medical expenses which the veteran must pay out of pocket.

D. Survivors Benefits

Several VA programs provide benefits to a veteran's surviving spouse, and in some instances to surviving children.

The VA's Definition of Eligible Marriage

To collect benefits as the surviving spouse of a veteran, you must have been married to the veteran for at least one year and remain married at the time of his or her death.

If you were divorced from the veteran, you cannot claim survivor benefits. Further, even if you were still married when the veteran died, you cannot claim survivor benefits if you marry someone else.

However, if you remarried after the veteran's death but that later marriage has ended, you may again be eligible for survivor benefits through your first spouse's record.

1. Dependency and Indemnity Compensation

A benefit known as Dependency and Indemnity Compensation (DIC) is paid to the surviving spouse of an armed forces member who died either while in service or from a service-connected disability after discharge. However, if the veteran was dishonorably discharged, no benefits will be paid to the survivor.

The amount of the DIC benefit is calculated based on the highest pay grade held by the deceased. The monthly benefits currently range from about \$920 for the survivor of low-ranking enlisted personnel to \$2,000 per month for the survivor of a high-ranking officer. There are additional payments if there are surviving children under age 18. DIC benefits are not reduced by any other income the surviving spouse may have, and are not affected by the amount of the survivor's assets.

2. Wartime Service Pension

The surviving spouse of a veteran may claim a monthly pension, regardless of whether death was connected to service, if that veteran would have been eligible for a wartime service pension. This survivor pension, like the veteran's wartime pension, requires that the survivor have a low income, taking into account money from any other pensions or Social Security benefits the surviving spouse receives.

A veteran's surviving children may also collect a survivor's wartime pension after the veteran's death. Survivor pension benefits are about \$550 per month for a single surviving spouse; more if there are dependent children.

3. Aid and Attendance

The Aid and Attendance (A&A) benefit is a special additional program to assist survivors who are eligible for DIC benefits and who are either living in a nursing facility or are housebound. If a survivor is in a nursing facility, an A&A benefit can add as much as \$300 per month to whatever DIC benefit he or she is already receiving; for a housebound survivor, the benefit is usually slightly less. The amount of the benefit depends on whether the survivor has additional sources of income, and on the survivor's medical expenses.

E. Medical Treatment

One of the most important benefits available to veterans is free or low-cost medical care. The VA operates more than 150 hospitals throughout the country. In addition, a great number of outpatient clinics provide health care for veterans. Also, specialized care may be available at no charge through a VA hospital, while the same care might be unavailable or beyond the veteran's means in the world of private medicine.

Basically, a veteran is eligible for medical care in a VA facility if he or she is unable to afford the care elsewhere. And dependents and survivors of a veteran who has service-connected disabilities, or who receives a veterans pension, are entitled to care in VA facilities if they are unable to afford private care. The VA can also pay for long-term care of an elderly or disabled veteran in a private nursing facility if there is no space in a VA facility.

Even if you qualify for treatment at a VA medical facility, however, you may not always

be able to get the care when you need it, or the treatment may be offered to you only at a VA facility far from your home. The reason for these limits, even for eligible patients, is that while there are close to 100,000 beds in VA hospitals, many more than 100,000 veterans and dependents need medical care.

To meet the demand for medical care, and particularly for the limited number of hospital beds, the VA has established a priority system for deciding who gets treatment directly from VA hospitals, clinics, and doctors:

- **Priority Group 1:** Veterans with service-connected disabilities rated 50% or more disabling.
- **Priority Group 2:** Veterans with service-connected disabilities rated 30% or 40% disabling.
- **Priority Group 3:** Veterans who are former POWs, were discharged for a disability incurred or aggravated in the line of duty, have service-connected disabilities rated 10% or 20% disabling, or were disabled by treatment.
- **Priority Group 4:** Veterans who are receiving aid and attendance or housebound benefits (see Section D3, above, for a description).
- **Priority Group 5:** Veterans with a 0% disability rating whose income and assets are below certain dollar limits.
- **Priority Group 6:** Gulf War veterans receiving care solely for Gulf War-related disorders not amounting to compensable disabilities, veterans with compensable 0% service-connected disabilities, and World War I veterans.
- **Priority Group 7:** All other veterans. If accepted for treatment, this group must pay a copayment for services.

Medicare and VA Medical Treatment

Many veterans who are eligible for VA medical treatment are also covered by Medicare. The general rule is that for any specific medical treatment, you can choose either of the benefits, but not both. This means that if you are treated at a VA facility but you are charged copayments by the VA, Medicare cannot pay for them. However, if you are treated by a private doctor or facility and the VA pays most but not all of the cost, Medicare may be able to pay some of the unpaid amount. If you are treated by a private doctor or facility and Medicare covers the bills, you cannot submit any unpaid portion to the VA.

There is a significant exception to this rule, which kicks in where the VA covers services that Medicare doesn't. For example, if the VA authorizes you to receive treatment at a private facility but does not cover all the services you receive, Medicare can pay for any of those services if Medicare does cover them.

Additional Veterans' Programs Are Available

This chapter explains the major programs for which older veterans are usually eligible. However, the VA administers many more programs that a veteran may find useful.

The VA also provides financial support for education and vocational training, life insurance, home loans and other housing assistance, and a National Cemetery burial program.

Eligibility requirements vary for each of these programs, but either active duty or active duty for training are usual requirements. (See Section A, above, for definitions.)

F. Getting Information and Applying for Benefits

The VA maintains large Regional Offices in major cities, and many smaller offices known as Veterans Centers in cities both large and small. Although applications are processed and decisions made at the Regional Offices, the Veterans Centers provide information about benefits and claims. The Veterans Centers can also provide you with application forms for various benefits, assist you in filling them out, and help you with any appeal if you are denied a benefit.

To find either the Regional Center or the Veterans Center nearest you, look in the Government Pages in your telephone directory under United States Government, Veterans Affairs Department. Or, call the VA's national benefits information line at 800-827-1000, or their health benefits line at 800-222-8387. The VA also has an extensive website at www.va.gov.

When appearing in person at a Veterans Center, the veteran should bring discharge papers, medical records if applying for disability benefits, and wage or tax records indicating current income if considering an application for wartime service pension benefits.

A surviving spouse should bring the veteran's discharge or other military papers, marriage certificate, recent wage or tax records, and birth certificates for any minor children, or for a surviving child up to age 22 who is disabled or a full-time student, plus evidence of their disability or student status.

Requests for medical treatment or admission to a VA medical facility, or VA coverage of medical treatment by a private facility, are usually handled at the admitting office of the VA medical facility or clinic itself. A veteran seeking medical attention at a VA hospital should (after calling to find out its appointment procedures) bring discharge papers, documents indicating that the veteran is receiving VA disability benefits and whether or not any medical condition is service-connected, and documents indicating whether the veteran is receiving a VA pension.





Medicare

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The horrendous cost of medical care and medical insurance, coupled with the lack of a comprehensive health plan available to all, has rightfully been termed a national disgrace. Yet whenever discussion of this monumental failure makes its way into the political arena, proposals for creating a decent health care system run into dual roadblocks. The first is mounted by heavily bankrolled corporate interests—pharmaceutical, medical technology, and hospital companies; the insurance industry; and most doctors' groups—who fight any limits on their profit making. The second is set up by politicians who refuse to take any steps that might be seen as opposing the interests of the moneyed portion of the population.

In 1965, however, over howls of protest by many in corporate boardrooms and government, the Medicare national health insurance system was introduced as a way of providing a certain amount of guaranteed coverage for older citizens. And for over 40 years now, Medicare has been carving an inroad into the mountain of consumer health care costs.

Medicare pays for most of the cost of hospitalization and much other medical care for older Americans, but it still leaves almost half of all medical costs unpaid. Medicare now provides this coverage for over 42 million people, most of them age 65 and over.

Despite its broad reach, Medicare does not pay for many types of medical services, and it pays only a portion of the costs of other services. And with attacks on Medicare gaining political momentum, the chunk of medical care costs Medicare will continue to cover is likely to be even smaller.

This chapter discusses the Medicare system, what it covers, and how much it pays. Chapter 12 shows you how to apply for Medicare and take full advantage of its benefits.

The chapters that follow present detailed information about how to fill the gaps in Medicare coverage. Medigap supplemental insurance is discussed in Chapter 13, while the various Medicare managed care plans are sorted out in Chapter 14. If you have low income and few assets, Chapter 15 explains the government Medicaid program, which provides free coverage in place of buying private insurance or a managed care plan.



Congress Amends Medicare, Adding Prescription Drug Coverage

At the end of 2003, and after major public attention and pressure, Congress passed large-scale revisions to the Medicare program. Topping the list of important changes was the addition of coverage for prescription drug costs. Unfortunately, the new plan, which goes into effect in 2006, will do little more than encourage people to purchase a separate insurance policy for drug coverage. Overall drug costs will continue to soar—in fact, the law specifically bars the government from negotiating with drug companies for lower prices on behalf of Medicare patients. Critics point out that the net result will be to push people out of the Medicare system and provide a huge windfall for the insurance industry. There will be premiums, large copayments, and amounts left uncovered by the plan, so seniors will continue to spend large out-of-pocket amounts for medicines.

Details of the coverage and its cost are still being developed. Congress is already considering changes to the plan—and, with many months to go, advocacy groups are gearing up to push for further changes.

Of immediate concern for Medicare beneficiaries is what to do about sky-high prescription drug costs until 2006. Section G of this chapter lays out the public and private plans and programs currently available to help Medicare recipients cut their prescription drug costs, as well as the stopgap drug discount cards Medicare has offered since mid-2004.

The years 2003 to 2005 have seen other changes in Medicare that were not part of the new legislation. These include some expanded coverage for preventive screening, some brain scans, and treatment for obesity. See Sections C through F of this chapter for a full analysis of this coverage.

A. The Medicare Maze

There are two different ways that someone eligible for Medicare can receive the program's benefits. The first way is called "fee-for-service," sometimes also called "traditional Medicare" or "basic Medicare." With this type of Medicare coverage, a beneficiary can receive care from any doctor, hospital, clinic, or other provider who accepts Medicare patients. Medicare pays the provider a fee for each specific service. For services Medicare does not fully pay, the patient has three choices. The patient can choose to:

- pay out of pocket
- buy a private supplemental insurance policy—commonly known as "medigap" insurance—that pays much of what Medicare does not (see Chapter 13), or
- apply for Medicaid coverage (called Medi-Cal in California), a federal program for low-income people that pays almost all of those health care costs that are not picked up by Medicare.

The second way that people can receive Medicare benefits is through a managed care plan, called Medicare Advantage (formerly Medicare + Choice), offered by different insurance companies and managed care providers. These plans cover everything that traditional Medicare does, plus some services Medicare doesn't cover at all. And, they eliminate some of the copayments and deductibles required by traditional Medicare.

These managed care plans—usually offered by health maintenance organizations (HMOs)—are usually less expensive than the combination of traditional Medicare with a medigap supplemental insurance policy. However, managed care plans limit the health care providers a patient may use, and sometimes block referrals to

specialists, or limit extra care. They also have a history of changing the amounts they charge enrollees, of limiting or eliminating specific coverage, and of suddenly dropping coverage for Medicare recipients in entire geographic areas.



Once you're Medicare eligible, your retirement health coverage may be cut off. About 12 million Medicare beneficiaries receive some kind of retirement health benefits from their former employers. These benefits often dovetail with Medicare coverage, paying its deductibles and copayments, and covering services Medicare does not, including prescription drugs. However, under a rule issued in mid-2004 by the federal Equal Employment Opportunity Commission, employers are now free to reduce that health coverage or eliminate it entirely for retirees age 65 or older—even if they maintain the coverage for younger retirees. If this happens to you, you'll have to fill in the gaps in Medicare coverage some other way, as described in Chapters 13 through 15.

B. Medicare: The Basics

Medicare is a federal government program that assists older and some disabled people with paying their medical costs. The program is divided into two parts. Part A is called hospital insurance, and covers most of the costs of a stay in the hospital, as well as some follow-up costs afterward. Part B, medical insurance, pays some of the costs of doctors and outpatient medical care.

Medicare is operated by the Centers for Medicare and Medicaid Services (CMS), part of the Department of Health and Human Services, in cooperation with the Social Security Administration. The Medicare program's daily business, however, is run by private companies, called carriers or intermediaries, operating under contract with the federal government.

Most of a patient's direct contact with Medicare happens with the company—Blue Cross, Blue Shield, or other large insurance company—that administers Medicare in his or her state.

One of the outrages of the current Medicare political storm is that giving Medicare administrative monopolies to these bloated, private insurance companies drives up the cost to the public.

Health Coverage If You Stop Working Before Age 65

Medicare and Medicare supplemental insurance and managed care plans are available to most people age 65 and older. But what if you stop working before age 65—either because you choose to retire, are laid off, or lose your business? Chances are you'll lose your health insurance at the same time. Then the issue becomes finding affordable medical coverage, and a plan that will cover preexisting conditions, to fill the gap until you turn 65.

Here are some ways to try to stretch your medical coverage without turning to the open market for an individual health insurance policy:

- **Take advantage of continued health insurance from your employer.** If you are entitled to retirement benefits from your employer, these may include continued health care coverage. Be aware, however, that your employer is permitted to drop that retiree health coverage once you turn 65 and are eligible for Medicare. If you aren't automatically eligible for retiree health coverage, you may be able to negotiate continued health coverage with your employer as part of your severance package, or with the purchaser of your business as part of its sale price.
- **Convert to individual coverage under an employer-sponsored plan.** Some employer-sponsored insurance plans permit employees to convert their group coverage to individual coverage upon leaving their employment. If your plan allows this, you will probably have to pay all the premiums—and they may well be higher than when you were part of a group policy. Nevertheless, such conversion permits you to continue coverage without going through a screening process, which is extremely important if you have a preexisting medical condition or have been treated for a serious illness or condition within the previous ten years.
- **Continue coverage under COBRA.** The U.S. Congress passed the Consolidated Budget Reconciliation Act (COBRA) in 1985. It mandates a period of continued health coverage for people who lose or leave their jobs (unless they're fired for gross misconduct) and their spouses and children. It also applies to employees whose hours are reduced below the number that qualifies them for health benefits. If you qualify, you are entitled to buy 18 months of health insurance from the same company following the end of your employer-sponsored coverage. However, the extent of your coverage may be reduced, and you'll have to pay the full premiums—which will probably be higher than what your employer paid for you. For more information, see [Federal Employment Laws: A Desk Reference](#), by Amy DelPo and Lisa Guerin (Nolo), or the Department of Labor website at www.dol.gov. Also, check with the agency in your state dealing with labor and employment—most states have passed their own laws expanding on COBRA's coverage.
- **Look for union, professional, or fraternal group insurance.** Despite being out of work, you may still be eligible to keep or start up membership in a union or a professional or fraternal organization. Some of these organizations offer group medical insurance. These policies may be a bit cheaper than individual policies, and you may not have to pass a health screening to enroll.
- **Claim early Medicare based on disability.** If you stop working because of a disability and you qualify for Social Security disability benefits, you will qualify for full Medicare coverage once you have received those disability benefits for 24 months. (See Chapter 3 for a full discussion of Social Security disability benefits.)

I. Medicare and Medicaid: A Comparison

People are sometimes confused about the differences between Medicare and Medicaid. Medicare was created to deal with the high medical costs that older citizens face relative to the rest of the population—especially troublesome given their reduced earning power. However, eligibility for Medicare is not tied to individual need. Rather, it is an entitlement program; you are entitled to it because you or your spouse paid for it through Social Security taxes.

Medicaid, on the other hand, is a federal program for low-income, financially needy

people, set up by the federal government and administered differently in each state.

Although you may qualify for and receive coverage from both Medicare and Medicaid, you must meet separate eligibility requirements for each program; being eligible for one program does not necessarily mean you are eligible for the other. Also, Medicaid pays for some services that Medicare does not.

Medicaid is explained in full in Chapter 15, but the chart that follows may help you understand the basic differences between the two programs.

A Comparison of Medicare and Medicaid

MEDICARE

MEDICAID

WHO IS ELIGIBLE

Medicare is for almost everyone 65 or older; rich or poor; for certain people on Social Security disability; and for some people with permanent kidney failure.

Medicare is an entitlement program; people are entitled to Medicare based on their own or their spouse's Social Security contributions, and on payment of premiums.

Medicaid is for low-income and financially needy people, including those over 65 who are also on Medicare.

Medicaid is an assistance program only for the needy.

WHO ADMINISTERS THE PROGRAM

Medicare is a federal program. Medicare rules are the same all over the country.

Medicare information is available at your Social Security office or through the Centers for Medicare & Medicaid.

Medicaid rules differ in each state.

Medicaid information is available at your local county social services, welfare, or Department of Human Services office.

COVERAGE PROVIDED

Medicare hospital insurance (Part A) provides basic coverage for hospital stays and post-hospital nursing facility and home health care.

Medicare medical insurance (Part B) pays most of basic doctor and laboratory costs, and some of other outpatient medical services, including medical equipment and supplies, home health care, and physical therapy. It covers none of the cost of prescription drugs.

Medicaid provides comprehensive inpatient and outpatient health care coverage, including many services and costs Medicare does not cover, most notably, prescription drugs, diagnostic and preventive care, and eyeglasses. The amount of coverage, however, varies from state to state.

COSTS TO CONSUMER

You must pay a yearly deductible for both Medicare Part A and Part B. You must also pay hefty copayments for extended hospital stays.

Under Part B, you must pay the 20% of doctors' bills Medicare does not pay, and sometimes up to 15% more. Part B also charges a monthly premium.

Medicaid can pay Medicare deductibles and the 20% portion of charges not paid by Medicare. Medicaid can also pay the Medicare premium.

In some states, Medicaid charges consumers small amounts for certain services.

C. Part A Hospital Insurance

Medicare is divided into two parts. Hospital insurance, referred to as Part A, covers most of the cost of care when you are at a hospital as an inpatient. (Your remaining, noninpatient medical costs are covered, at least in part, by Medicare Part B, discussed in Section E, below.)

I. Who Is Eligible

There are two types of eligibility for Medicare Part A hospital insurance. Most people age 65 and over are eligible for free coverage, based on their work records or on their spouse's work records. People over 65 who are not eligible for free Medicare Part A coverage can nevertheless enroll in it and pay a monthly fee. (See Chapter 12 for enrollment procedures.)

a. Free Coverage

Most people age 65 and over are automatically eligible for Medicare Part A hospital insurance. They do not have to pay any monthly premium for it; the coverage is free.

The two largest categories of people automatically eligible are:

- People age 65 or older who are eligible for Social Security retirement benefits, or have civil service retirement work credits equal to an amount that would make them eligible for Social Security retirement. (See Chapters 2 and 9 regarding eligibility for these two programs.) You are automatically eligible for Medicare coverage even if you do not actually begin collecting your retirement benefits at 65, as long as

you could have started collecting them. If you wait to claim retirement benefits until after 65, you may still begin Medicare coverage at 65. However, if you begin collecting retirement benefits before age 65, you must wait until age 65 to get Medicare coverage.

- People age 65 or older who are eligible for Social Security dependents or survivors benefits. Note that people who are age 65 and eligible for dependents benefits when a spouse turns 62 are entitled to Medicare coverage whether or not the spouse actually claims retirement benefits.

Some additional categories of people may also be eligible for free coverage:

- People who reached age 65 before January 1, 1968, even if not eligible for Social Security benefits, if they are U.S. citizens or lawfully in the United States for five consecutive years immediately before applying for Medicare.
- Women who reached age 65 before 1974, and men who reached 65 before 1975, who have three Social Security work credits from covered employment for each year after 1966 before reaching age 65. (See Chapter 1, Section D, regarding how work credits are earned.)
- People of any age who have been entitled to Social Security disability benefits for 24 months.
- Anyone who has permanent kidney failure requiring either a kidney transplant or maintenance dialysis, if the person or spouse has worked a certain amount at jobs covered by Social Security. For details of this coverage, check with your local Social Security office. If you have any trouble qualifying for Medicare based on kidney failure, contact the National Kidney Foundation, 30 East 33rd Street, New York, NY 10016; 800-622-9010, www.kidney.org.

b. Paid Coverage

If you are age 65 or over but not automatically eligible for free Part A hospital insurance coverage, you can still enroll in the Medicare hospital insurance program by paying a monthly premium. The amount of your premium depends on how many Social Security work credits you or your spouse have earned, and on how long after your 65th birthday you apply for coverage.

If you or your spouse have 30 to 39 work credits, the monthly premium is lower: \$206 per month in 2005. If neither you nor your spouse have 30 work credits, the monthly premium is higher: \$375 per month in 2005. Also, if you enroll in Part A coverage more than a year after you turn 65, your premium will be 10% higher than these monthly figures.

If you enroll in paid Part A hospital insurance, you must also enroll in Part B medical insurance, for which you pay an additional monthly premium. (See Section E, below, regarding Part B insurance.) However, you may enroll in Part B without Part A.



Make sure to compare costs. If you are considering enrolling in and paying for Medicare Part A hospital insurance, it may be cheaper for you to do so through an HMO or a health plan. The cost of such coverage will be part of the broader coverage and cost for full participation in the HMO or health plan, which will vary among different plans. Before purchasing Medicare Part A coverage as an individual, compare premiums and benefits of various group plans.

2. Types of Care Covered

Part A hospital insurance pays much of the cost you incur directly from a hospital as part of inpatient care. Under some circumstances, it also covers some of the cost of inpatient treatment in a skilled nursing facility (see Section 6, below, for details) and by a home health care agency (see Section 7). Doctors' bills are not included in Part A coverage; they are covered under Medicare Part B.

A few basic rules apply to all claims under Part A hospital insurance coverage, whether for inpatient care at a hospital or nursing facility or for home health care.

Expanded Coverage for Defibrillators

For quite a while, Medicare has covered some surgeries to place heart-shocking devices called "implantable cardioverter defibrillators" (ICDs) into patients considered to be at high risk of a repeat heart attack. However, Medicare limited its coverage of the surgery and ICD device to a relatively small number of patients whom it thought could benefit from them.

But Medicare has recently changed its policy to greatly expand the number of patients who qualify for coverage of an ICD implant. So, if your cardiologist considers you to be a good candidate for an ICD, have the doctor propose the surgery to Medicare to see if you fit within the new, expanded coverage guidelines.

a. Doctor-Prescribed Care

The care and treatment you receive must be prescribed by a licensed physician.

b. Reasonable and Necessary Care

The inpatient care you receive must be medically reasonable and necessary—that is, the type of care that can be provided only at a hospital or nursing facility. If you could receive the particular treatment just as well and safely as a hospital outpatient, at the doctor's office, or at your home, Part A will not cover you if you receive that treatment as an inpatient. Also, Part A will not normally cover the cost of hospitalization for elective or cosmetic surgery—except for reconstructive surgery after an accident or disfiguring illness—because these are not considered medically necessary.



Custodial care isn't covered. Part A hospital insurance covers only skilled medical treatment of an illness or injury. It does not pay for a stay in a hospital or nursing facility, or for care from a home health agency, when the services you receive are primarily to make life more comfortable—to help with dressing, eating, bathing, or moving around. In reality, distinctions between medical treatment and custodial care sometimes blur, which results in disputes between Medicare administration and patients.

3. Medicare-Approved Facility or Agency

The Medicare authorities issue licenses to hospitals, nursing facilities, and health care agencies certifying that they meet its standards for quality of care and staffing. Medicare will cover only care that is provided by facilities it approves.

Find out in advance if the facility to which you plan to be admitted, or the home health care agency you intend to hire, is approved by Medicare and accepts Medicare payment. Check with the facility's admissions services or administrator's office, or with the administrator of the home health care agency.

Nowadays it is rare to find a hospital or skilled nursing facility that is not Medicare-approved. Some home health care agencies, however, are not Medicare-approved. That does not necessarily mean that the agency is not reputable. Under most circumstances, Medicare Part A pays for very little home care, anyway. (See Section 7, below, regarding home care coverage.) So if Medicare is not going to cover much of your costs, you may want to switch to an agency that is good and less expensive, but not Medicare-approved, as soon as your Medicare coverage ends.

4. Facility Review Panel Approval

Each hospital and nursing facility has a panel of doctors and administrators that reviews your doctor's decision to treat you as a hospital inpatient or at a nursing facility. The panel usually

agrees with your doctor's initial decision. And the panel and your doctor usually agree on how long you should remain in the facility. Sometimes, though, the panel decides you do not need to be an inpatient to receive certain treatment. Or it decides that you could be discharged from the facility earlier than your doctor recommended. The panel and your doctor will then consult with one another. Usually, they reach an agreement.

If, however, your doctor and the review panel do not agree that you require inpatient care, or they differ as to your discharge date, the question of whether Medicare Part A will pay for your inpatient care will be referred to a Peer Review Organization (PRO). (See Chapter 12, Section F, for more on the review process.)



Psychiatric stays are limited. Medicare Part A covers inpatient psychiatric hospital care. However, if you receive inpatient care in a psychiatric hospital, the total number of days covered is limited. (See Section D3, below, for details.)

5. Foreign Hospital Stays

Generally, Medicare does not cover you outside the United States, Puerto Rico, the Virgin Islands, Guam, and American Samoa. There are, however, three exceptions to this rule:

- If you are in the United States when an emergency occurs and a Canadian or Mexican hos-

pital is closer than any U.S. hospital with emergency services, Medicare will help pay for your emergency care at that foreign hospital.

- If you live in the United States and a Mexican or Canadian hospital is closer to your home than the nearest U.S. hospital, Medicare can cover your care there even if there is no emergency.
- If you are in Canada while traveling directly to Alaska from one of the other states, or from Alaska to one of the other states, and an emergency arises, you may be covered for your care at a Canadian hospital. However, Medicare will not cover you if you are vacationing in Canada.



Consider buying travel insurance. Since there is no Medicare protection for you while you are traveling outside the United States, and if you have no other medical insurance that would cover you while traveling, it might be wise to look into traveler's insurance. These short-term policies are available for a one-time-only premium. A travel agent should be able to give you details. Many medigap supplemental insurance policies and Medicare managed care plans provide coverage for foreign travel emergencies. If you have such coverage, you may not need extra travel insurance.

Inpatient Care Generally Covered by Part A

The following list gives you an idea of what Medicare Part A does, and does not, pay for during your stay in a participating hospital or skilled nursing facility. Remember, though, even when Part A covers a cost, there are significant financial limitations on its coverage. (See Section D, below, for the dollar figures.)

Medicare Part A hospital insurance covers:

- a semiprivate room (two to four beds per room); a private room if medically necessary
- all meals, including special, medically required diets
- regular nursing services
- special care units, such as intensive care and coronary care
- drugs, medical supplies, and appliances furnished by the facility, such as casts, splints, wheelchair; also, outpatient drugs and medical supplies if they permit you to leave the hospital or nursing facility sooner
- hospital lab tests, X-rays, and radiation treatment billed by the hospital
- operating and recovery room costs
- blood transfusions; you pay for the first three pints of blood, unless you arrange to have them replaced by an outside donation of blood to the hospital, and
- rehabilitation services, such as physical therapy, occupational therapy, and speech pathology provided while you are in the hospital or nursing facility.

Medicare Part A hospital insurance does not cover:

- personal convenience items such as television, radio, or telephone
- private duty nurses, or
- private room, when not medically necessary.

6. Skilled Nursing Facilities

A growing number of patients recovering from surgery or a major illness are referred by their doctors to skilled nursing facilities. These provide an important, less expensive alternative to hospitalization. Medicare may cover some of your costs of staying in a skilled nursing facility, but strictly limits how much it will pay. (See Section D4, below, for details.)

First, let's make sure your stay will be covered at all. You must meet two requirements before Medicare will pay for any nursing facility care. You must have recently stayed in a hospital, and your doctor must verify that you require daily skilled nursing care.

a. Prior Hospital Stay

Your stay in a skilled nursing facility must begin after you have spent at least three consecutive days, not counting the day of discharge, in the hospital—and within 30 days of being discharged. If you leave the nursing facility after coverage begins, but are readmitted within 30 days, that second period in the nursing facility will also be covered by Medicare.

Levels of Nursing Facility Care

Most nursing facilities provide what is called custodial care—primarily personal, nonmedical care for people who are no longer able to fully care for themselves. Custodial care often lasts months or years, and is not covered at all by Medicare. For the most part, custodial care amounts to assistance with the tasks of daily life: eating, dressing, bathing, moving around, some recreation. It usually involves some health-related matters: monitoring and assisting with medication, providing some exercise or physical therapy. But it is ordinarily provided mostly by personnel who are not highly trained health professionals, and does not involve any significant treatment for illness or physical condition.

A different, short-term kind of care known as skilled nursing facility care is covered by Medicare, although there are severe limits. (See Section D4, below, regarding these limits.) Skilled nursing facility care, which takes place in a hospital's extended care wing or in a separate nursing facility, provides high levels of medical and nursing care, 24-hour monitoring, and intensive rehabilitation. It is intended to follow acute hospital care due to serious illness, injury, or surgery—and usually lasts only a matter of days or weeks.

b. Requiring Daily Skilled Nursing Care

Your doctor must certify that you require daily skilled nursing care or skilled rehabilitative services. This care includes rehabilitative services by professional therapists, or skilled nursing treatment, such as giving injections, changing dressings, monitoring vital signs, or administering medicines or treatments, which cannot be performed by untrained personnel. This daily care must be related to the condition for which you were hospitalized.

If you are in a nursing facility only because you are unable to feed, clothe, bathe, or move yourself, even though these restrictions are the result of your medical condition, you are not eligible for Part A coverage. This is because you do not require skilled nursing care as defined by Medicare rules. However, if you require occasional part-time nursing care, you may be eligible for home health care coverage (described in Section 7, below).

The nursing facility care and services covered by Medicare are similar to what is covered for hospital care. They include:

- a semiprivate room (two to four beds per room); a private room if medically necessary
- all meals, including special, medically required diets
- regular nursing services
- special care units, such as coronary care
- drugs, medical supplies, treatments, and appliances provided by the facility, such as casts, splints, wheelchair, and

- rehabilitation services, such as physical therapy, occupational therapy, and speech pathology, provided while you are in the nursing facility.

Medicare coverage for a skilled nursing facility does not include:

- personal convenience items such as television, radio, or telephone
- private duty nurses, or
- a private room when not medically necessary.

7. Home Health Care

Progressive health care professionals often encourage people to get out of hospitals and nursing facilities and into their own or family members' homes while recovering from injury or illness. With less honorable motives, insurance companies also pressure hospitals to release patients earlier so that if they continue to receive care, it will be a less costly variety at home.

In response to both these movements, many new home health care agencies have sprung up. You're increasingly likely to find such an agency in your local area. Most are able to provide care for patients who no longer need high-level care in a hospital but who still require part-time nursing or physical therapy.

Pros and Cons of Home Health Care

The benefits of properly administered home health care can be enormous. In the first place, the surroundings—your own home, or that of a friend or relative—are often more conducive to a speedy recovery than the impersonal and sometimes frightening environment of a hospital. You have familiar things around you, your friends and family can come and go without worrying about “visiting hours,” and they can lend a hand with your care. You have greater privacy and are free from dreadful hospital routines and late-night noise and lights. And home health care is far less expensive than a stay in the hospital or in a nursing facility.

On the other hand, home health care is not always the best solution. Hospitals sometimes push people out the door before they are well or strong enough, and as a result the people may take longer to recover, or suffer more pain and discomfort, than they would have if they had remained in the hospital just a few days more. This is particularly true when a patient does not have family or friends available to supplement the care provided by a home care agency.

If you are interested in home health care after a stay in the hospital, or as an alternative to a stay in a hospital or nursing facility, contact a home health care agency recommended by your doctor or the hospital discharge planner. The discharge planner can even contact an agency for you. If home care follows a hospital stay, it may be covered by Medicare, as long as a Medicare-approved agency is used.

You may also get help in locating home health care agencies from a community health organization, visiting nurses association, United Way, Red Cross, or neighborhood senior center.



For a complete discussion of long-term home health care, particularly for older people, and how to finance it, see [Long-Term Care: How to Plan & Pay for It](#), by Joseph Matthews (Nolo). See the back of this book for ordering information, or go online at www.nolo.com.

a. Coverage Provided

Part A home health care coverage requires a prior three-day hospital stay. Home care without a prior hospital stay may be covered by Part B. If you qualify for home care coverage, Medicare pays for the following services provided by a participating home health care agency:

- part-time skilled nursing care—usually two to three visits per week in a plan certified by a physician, and
- physical therapy and speech therapy.

If you are receiving part-time skilled nursing care, physical therapy, or speech therapy, Medicare can also pay for:

- occupational therapy
- part-time home health aides
- medical social services, and
- medical supplies and equipment provided by the agency, such as a hospital bed, a walker, or respiratory equipment.

However, Medicare will not pay for a number of services sometimes provided as part of home health care, including:

- full-time nursing care

- drugs and biologicals administered at home
- meals delivered to your home, and
- housekeeping services.

b. Restrictions on Coverage

Despite the obvious financial as well as recovery advantages of home health care, Medicare coverage for it is severely restricted.

- The agency providing the care must participate in Medicare—meaning it must be approved by Medicare and must accept Medicare payment. Many agencies do not participate in Medicare, so find out before making arrangements.
- You must be confined to your home by an injury, illness, or other medical condition. If you need nursing care or other medical services but you are physically able to leave home to receive it, you might not be eligible for Medicare home health care coverage.
- You must initially require part-time skilled nursing care or physical or speech therapy. After your home health care coverage begins, Medicare can continue to cover your home care even if you need only occupational therapy—which helps you regain job skills you may have lost because of the illness or injury. Occupational therapy alone, however, cannot justify home health care coverage in the first place.
- Your doctor must determine that you need home health care and must help set up a care plan in cooperation with the home health care agency. If your doctor has not mentioned home care to you but you feel it would be a good idea, make your wishes known. Most doctors will prescribe home

care, can give you a referral to a Medicare-approved agency, and will cooperate with the home health care agency.

8. Hospice Care

Hospice care is home health care provided to a terminally ill patient who is in the last six months or so of life (as certified by his or her physician). Hospice care focuses not on treating the illness or fostering recovery, but on making the patient as comfortable as possible. Good hospice care may combine the efforts of family, doctors, nurses, social workers, dietitians, and clergy, as well as physical therapists and other trained caregivers.

Medicare does not provide 24-hour hospice care, but it does cover visits by health care workers to the patient's home on a regular basis—daily if necessary—including a hospice nurse on 24-hour call. Significantly, and unlike other nonhospital Medicare coverage, Medicare also pays for any medication prescribed by a physician for symptom management and hospice patient comfort.

Medicare may also cover up to five days of inpatient care in a hospital or skilled nursing facility to give the family or other primary caregivers a respite from their duties. If approved by the hospice, this five-day respite care period may be repeated during a patient's care.

a. Coverage Provided

Medicare can cover nearly the full cost of hospice care. Hospice care covered by Medicare includes:

- physician services provided by a physician connected with the hospice—Medicare Part B will continue to cover services provided by the patient's personal doctor
- nursing care
- medical supplies and appliances
- drugs for management of pain and other symptoms
- health aide and homemaker services
- physical and speech therapy, and
- medical social services, counseling, and dietary assistance.

b. Restrictions on Coverage

Care must be provided by a Medicare-approved hospice, under a plan developed by the hospice and the patient's attending physician. The patient's doctor and the hospice's medical director must certify that the patient is terminally ill, with a life expectancy of six months or less. And the patient must sign a statement choosing hospice care instead of standard Medicare Part A benefits.

c. Right to Return to Regular Medicare Coverage

Some people do not take advantage of hospice care, out of a misunderstanding about how it impacts their Medicare coverage. They may mistakenly fear that they'll permanently lose their regular Medicare coverage, won't be covered by Medicare for hospitalizations, or will outlive their six-month diagnosis and be stuck without Medicare coverage. The fact is, however, that a Medicare patient may disenroll from hospice care and return to regular

Medicare coverage at any time. If the patient's doctor certifies that the six-month life expectancy no longer applies, the patient can "graduate" from hospice and return to regular Medicare.

This sometimes occurs with degenerative diseases such as congestive heart failure or emphysema—the physician's best time estimate may be off by years. Most people who disenroll do so after the first or second 90-day evaluation period.

D. How Much Medicare Part A Pays

To understand any Medicare decision about how much of your hospital, nursing facility, or home care bill it will pay, you have to know the basics of Part A payments. Those basics include benefit periods (see Section D1, below) and deductible and coinsurance amounts (see Section D2, below).

I. Benefit Period or Spell of Illness

How much Medicare Part A pays depends on how many days of inpatient care you have during what is called a benefit period or spell of illness.

A benefit period or spell of illness refers to the time you are treated in a hospital or skilled nursing facility, or some combination of the two, for a particular illness or injury. The benefit period begins the day you enter the hospital or skilled nursing facility as an inpatient—and continues until you have been out for 60 con-

secutive days. If you are in and out of the hospital or nursing facility several times but have not stayed out completely for 60 consecutive days, all your inpatient bills for that time will be figured as part of the same benefit period.

Two Benefit Spells May Be Better Than One

You can get more total days of full Medicare coverage during two spells of illness than in just one. As a result, it can be in your financial interest to stretch your hospital or nursing facility stays into two benefit periods, if possible. For example, using home health care may help you stay out of the hospital or nursing facility for 60 days before you must return as an inpatient for further treatment. If the timing of your inpatient treatment could be somewhat flexible, discuss that timing and its effect on Medicare coverage with your doctor.

Example: Oscar is in the hospital with circulatory problems, being treated with medication. His doctor recommends surgery, operating on one leg at a time, monitoring the first leg before attending to the second. Oscar and his doctor plan the dates of surgery so that he will be released from the hospital and will convalesce at home, with the help of home health care services, for more than 60 days before he returns to have the second operation.

This way, Medicare will consider the time Oscar spends in the hospital after the second surgery to be part of a new spell of illness, even though it results from the same condition that made the first operation necessary. If there had not been a 60-day break between hospitalizations, Oscar would have been in the hospital a total of more than 60 days and would have had to pay a hefty coinsurance amount for every day after his 60th day in the hospital—up to his 90th day.

2. Hospital Bills

Medicare Part A pays only certain amounts of a hospital bill for any one benefit period.

a. The Deductible Amount

For each benefit period, you must pay an initial amount before Medicare will pay anything. This is called the hospital insurance deductible. The deductible is increased every January 1. In 2005, the amount was \$912.

b. First 60 Days Hospitalized

For the first 60 days you are an inpatient in a hospital during one benefit period, Part A hospital insurance pays all of the cost of covered services. However, nonessentials, such as televisions and telephones, are not covered. (See Section C2, above, for details of Part A coverage.) You pay only your hospital insurance deductible. If you are in more than one hospital, you still pay only one deductible per benefit period—and Part A covers 100% of all your covered costs for each hospital.

c. 61 Through 90 Days

After your 60th day in the hospital during one spell of illness, and through your 90th day, each day you must pay what is called a “coinsurance amount” toward your covered hospital costs. Part A of Medicare pays the rest of covered costs. In 2005, this daily coinsurance amount was \$228; it goes up every year.

d. Reserve days

Reserve days are a last resort coverage. They can help pay for your hospital bills if you are in the hospital more than 90 days in one benefit period. But the payment is quite limited. If you are in the hospital for more than 90 days in any one spell of illness, you can use up to 60 additional reserve days of coverage. During those days, you are responsible for a daily coinsurance payment. In 2005, the reserve days coinsurance amount was \$456 per day. Medicare pays the rest of covered costs.

You do not have to use your reserve days in one spell of illness; you can split them up and use them over several benefit periods. But you have a total of only 60 reserve days in your lifetime. Whatever reserve days you use during one spell of illness are gone for good. In the next benefit period, you would have available only the number of reserve days you didn't use in previous spells of illness.



Try to save up your reserve days. Even if you are in the hospital for more than 90 days, you may want to save your reserve days for an even rainier day. For example, you may not want to use your reserve days if you currently have some private insurance, such as from an employer, that can help cover the costs of those extra days of hospitalization, but you may not have that insurance later in life.

Example: Bert had a serious stroke, followed by several complications involving kidney failure and pneumonia. For six months, he was in and out of both a hospital and a skilled nursing facility (SNF), for a total of 121 days. Because Bert never spent 60 consecutive days out of the hospital or SNF, all his inpatient treatment was considered part of the same “benefit period.” So when his combined time in the hospital and SNF reached 91 days, he had no choice but to begin using up his “reserve days” coverage. He used 20 reserve days during this benefit period, leaving him with only 40 reserve days for the remainder of his lifetime.

If Bert had remained out of the hospital and SNF for 60 consecutive days during any part of this stretch of treatment, he would not have had to use up any reserve days. Or, if his condition had permitted it, he might have been able to receive some care in an intermediate-level or custodial care nursing facility instead of in an SNF. However, this would have been a practical alternative only if he had some supplemental health coverage that would have paid for some or all of this level of care (Medicare doesn’t cover it at all).

Or, if Bert’s condition had permitted, he might have received some care at home from a Medicare-approved home health care agency. (See Section 5, below.) Medicare would have paid the full amount of this care. And it would not have affected his right to receive coverage when he needed to return to the hospital or SNF.

If you want to use your reserve days, you don’t have to make a formal request or fill out any form. Medicare will automatically apply them to cover your hospital bills—minus the daily coinsurance you have to pay.

But if you do not want to use those reserve days, or want to use some but not all of them, you must notify the hospital administrator or billing office. Plan ahead: You must submit your notification before the reserve days come up.

3. Psychiatric Hospitals

Medicare Part A hospital insurance covers a total of 190 days in a lifetime for inpatient care in a specialty psychiatric hospital (meaning one that accepts patients only for mental health care, not just a general hospital).

If you are already an inpatient in a specialty psychiatric hospital when your Medicare coverage goes into effect, Medicare may retroactively cover you for up to 150 days of hospitalization before your coverage began. In all other ways, inpatient psychiatric care is governed by the same rules regarding coverage and copayments as regular hospital care.

There is no lifetime limit on coverage for inpatient mental health care in a general hospital. Medicare will pay for mental health care in a general hospital to the same extent as it will pay for other inpatient care.

Example: During the five months before his 65th birthday, Horace spent 60 days in a psychiatric hospital. Those 60 days are subtracted from Horace’s lifetime total of 190 days of Medicare coverage in a psychiatric hospital. It leaves him with only 130 days more coverage under Part A for psychiatric hospitalization.

4. Skilled Nursing Facilities

Despite the common misconception that nursing homes are covered by Medicare, the truth is that it covers only a limited amount of inpatient skilled nursing care.

For each benefit period, Medicare will cover only a total of 100 days of inpatient care in a skilled nursing facility. For the first 20 of 100 days, Medicare will pay for all covered costs, which include all basic services but not television, telephone, or private room charges. For the next 80 days, the patient is personally responsible for a daily copayment; Medicare pays the rest of covered costs. In 2005, the copayment amount is \$114; the amount goes up each year.

Reserve days, available for hospital coverage, do not apply to a stay in a nursing facility. After 100 days in any benefit period, you are on your own as far as Part A hospital insurance is concerned. However, if you later begin a new benefit period, your first 100 days in a skilled nursing facility will again be covered.

Example: Bettina was hospitalized for several weeks with a broken hip. Upon leaving the hospital she was moved to a Medicare-approved SNF for rehabilitation and recovery. She remained in the SNF for 18 days, then went home. However, some setbacks in Bettina's healing forced her to return to the SNF a week later, where she stayed for another 12 days.

Because Bettina's stays in the SNF were not separated by 60 days, they were considered to be within the same "benefit period." Therefore, of her total 30 days in the SNF, Medicare will pay the entire amount of her bills (minus Bettina's phone calls to her brother in New Zealand) for only the first 20 days. For the remaining ten days, Bettina will be responsible for a copayment of \$114 per day, for a total of \$1,140.

If Bettina had had a medigap supplemental insurance policy (see Chapter 13) or a Medicare managed care plan (see Chapter 14) that covered Medicare nursing facility copayments, or had she been eligible for Medicaid (see Chapter 15), that insurance, care plan, or government program, would have paid all or part of the \$1,140. Having no such extra coverage, Bettina will have to pay out of her own pocket.

5. Home Health Care

Medicare Part A pays 100% of the cost of your covered home health care when provided by a Medicare-approved agency—and there is no limit on the number of visits to your home for which Medicare will pay.

Medicare will also pay for the initial evaluation by a home care agency, if prescribed by your physician, to determine whether you are a good candidate for home care. However, if you require durable medical equipment, such as a special bed or wheelchair, as part of your home care, Medicare will pay only 80%.

How Part A Payments Are Figured

To get a picture of how the overall Part A payment scheme works, an example of one person's hospital stay may be useful.

Annika was hospitalized for two weeks for a serious intestinal disorder, went home for a week, came back to the hospital for another ten days, was released again, and then had to return to the hospital after only a few days at home. After another week in the hospital, surgery became the only option. Annika spent two more weeks in the hospital recovering from the operation. Annika's hospital bill for all this treatment includes the following charges:

Semiprivate room, 45 days at \$604/day	\$27,200
Surgery surcharge	1,675
Intensive Care, 2 days at \$1,820/day	3,640
Laboratory	980
Medication	465
Whole blood (6 pints at \$32/pint)	192
Telephone	94
Television (6 weeks at \$70/week)	420
TOTAL DUE	\$34,666

Medicare will pay all covered costs less the \$912 deductible:

- 45 days in a semiprivate room (\$27,200)
- Surgery surcharge (\$1,675)
- Intensive care costs for two days (\$3,640)
- The second three pints of blood (\$96)
- Laboratory work (\$980)
- Medication (\$465).

Medicare will not pay for:

- Television or telephone costs; \$514 must be paid by Annika.
- The first three pints of blood. Annika must pay the \$96.

So Medicare covers \$34,056, minus the \$912 deductible, which Annika must pay. Annika also remains responsible for the \$610 in uncovered costs (phone, TV, and blood).

Remember, though, that Annika will still have to face her doctors' bills, whose coverage depends on her Medicare Part B medical insurance. (See Section E, below, for a discussion of Part B coverage.)



Home care makes good financial sense. The fact that Medicare will pay for an unlimited number of home health care visits makes home care a very good financial value—in addition to the recuperative benefits of being at home—compared to recovery in a hospital or nursing facility. If you are looking at a long period of convalescence, consider home health care as an alternative to a long siege in the hospital or nursing facility.

6. Hospice Care

Medicare pays 100% of the charges for hospice care, with two exceptions. First, the hospice can charge the patient up to \$5 for each prescription of outpatient drugs the hospice supplies for pain and other symptomatic relief. Also, the hospice can charge the patient 5% of the amount Medicare pays for inpatient care in a hospice, nursing facility, or the like every time a patient receives respite care.

There is no limit on the amount of hospice care you can receive. At the end of the first 90-day period of hospice care, your doctor will evaluate you to determine whether you still qualify for hospice—meaning your disease is still considered fatal and you are still estimated to have less than six months to live. A similar evaluation is made after the next 90-day period, and again every 60 days thereafter. If your doctor certifies that you are eligible for hospice care, Medicare will continue to pay for it even if it exceeds the original six-month diagnosis. And if your condition improves and you switch from hospice care back to regular Medicare coverage, you may return to hospice care whenever your condition warrants it.

Example: Ted is suffering from cancer. His doctors say it will be fatal within six months. Ted chooses to stop his chemotherapy treatment, stay at home, and receive hospice care there. After 90 days, however, Ted has not gotten any worse. His doctors determine that Ted's cancer has not progressed much and that Ted may live for another year or two. So Ted returns to traditional Medicare coverage.

After another nine months, however, Ted's cancer becomes much more aggressive. After Ted undergoes a short course of chemotherapy, his doctor estimates that Ted now has less than six months to live. Ted can now return to hospice care and stay on it for as long as his doctor still believes the cancer will be fatal within six months.

E. Part B Medical Insurance

The second half of Medicare coverage, Part B, is medical insurance. It is intended to help pay doctor bills for treatment either in or out of the hospital, as well as many of the other medical expenses you incur when you are not in the hospital.

I. Who Is Eligible

The rules of eligibility for Part B medical insurance are much simpler than for Part A: If you are age 65 or over and are either a U.S. citizen or a resident of the United States who has been here lawfully for five consecutive years, you are eligible to enroll in Medicare Part B medical insurance. This is true whether or not you are eligible for Part A hospital insurance.

Anyone who wants Part B medical insurance must enroll in the program. (See Chapter 12 for details on enrollment procedures.) Everyone enrolled must pay a monthly premium—\$78.20 in 2005. In most years, the premium is raised on January 1.

Medicare Medical Insurance Is Never Enough

Part B Medicare medical insurance is intended to pay for a portion of doctor bills, outpatient hospital and clinic charges, laboratory work, some home health care, physical and speech therapy, and a very few drugs and medical supplies. But there are heavy restrictions on what is covered and on how much is paid.

Private Medicare supplement insurance—often referred to as medigap insurance—may help you make up the difference. Many people also fill in the gaps in Medicare by joining an HMO or other managed-care health plan that combines basic Medicare coverage with supplemental benefits. (See Chapter 13 for a full discussion of medigap insurance.) If you cannot afford private supplement insurance, you may be eligible for Medicaid—a public program for people with low income and few assets. (See Chapter 15 regarding the Medicaid program.)

2. Types of Services Covered

Part B medical insurance is intended to cover basic medical services provided by doctors, clinics, and laboratories. However, the lists of services specifically covered and not covered are long, and do not always make a lot of common sense.

Making the effort to learn what is and is not covered can be important, since you may get the most benefits by fitting your medical treatments into the covered categories whenever possible.

a. Doctor Bills

Part B medical insurance covers medically necessary doctors' services, including surgery, whether the services are provided at the hospital, at a doctor's office, or—if you can find such a doctor—at home. Part B also covers outpatient medical services provided by hospital and doctor's office staff who assist in providing care, such as nurses, nurse practitioners, surgical assistants, and laboratory or X-ray technicians.



Medicare pays for a second opinion before surgery. Before undergoing surgery, it is usually medically wise to get a second opinion from another doctor. Second opinions often lead to the decision not to have surgery. Recognizing this, and the savings involved, Medicare will cover your obtaining a second doctor's opinion before undergoing any kind of surgery. And if the second doctor's opinion conflicts with the original doctor's recommendation for surgery, Medicare will pay for an opinion by yet a third doctor.

b. Outpatient Care and Laboratory Testing

Medicare medical insurance covers outpatient hospital treatment, such as emergency room or clinic charges, X-rays, injections which are not self-administered, and laboratory work and diagnostic tests. Lab work and tests can be done at the hospital lab or at an independent laboratory facility, so long as that lab is approved by Medicare.

**Beware of outpatient hospital charges.**

Medicare pays only a limited amount of outpatient hospital and clinic bills. And unlike most other kinds of outpatient services, Medicare places no limits on how much the hospital or clinic can charge over and above what Medicare pays. (See Section F7, below, for details.)

c. Ambulances

Part B medical insurance will cover the cost of transporting a patient by ambulance, if transport by any other means would not have been medically advisable. This may include not only emergencies, but also nonemergency trips following discharge from a hospital—for example, to the patient's home or to a nursing facility. Transporting residents of nursing facilities to see their doctors may also be covered. However, Medicare does not cover ambulance transport for regular visits from a person's home to a doctor's office, if the trip was arranged simply because the person needed some assistance.

If your doctor prescribes an ambulance for you, that makes it likely—but does not guarantee—that Medicare will cover the trip. If Medicare covers an ambulance trip, the ambulance

company must accept the Medicare-approved amount as full payment for its services. Medicare will pay 80% of that amount. You, or your medigap insurer or managed care plan (see Chapters 13 and 14 for descriptions of these plans), are responsible for paying the remaining 20%. The ambulance company may not bill you for any amount over that 20%.

If you need help getting to and from doctor visits, but an ambulance is not considered medically necessary, look into free transportation for seniors in your community. Call your local senior center or the senior information line or eldercare locator listed in the white pages of your telephone directory.

d. Administered Drugs

Drugs or other medicines administered to you at the hospital or doctor's office are covered by medical insurance. Medicare does not cover drugs you take by yourself at home, including self-administered injections, even if they are prescribed by your doctor. Exceptions to this rule are self-administered oral cancer medication, antigens, and immunosuppressive drugs, which are covered by Medicare. Also, flu shots and pneumonia vaccines are covered by Medicare, even though other vaccinations are not; the flu shot you can obtain on your own, but the pneumonia vaccination requires a doctor's prescription.

2005 Demonstration Program for Certain Self-Administered Drugs

To fill the gap until fuller Medicare prescription drug coverage goes into effect in 2006, Medicare has launched a “demonstration” program. For the first 50,000 people who apply, Medicare will pay a large share of the cost of certain oral and self-injectable drugs and biologicals. (Medicare has developed a list of covered drugs and the life-threatening diseases you must be taking them for.) These drugs replace medicines that previously had to be administered in the doctor’s office. Among the more common illnesses on Medicare’s list are:

- several forms of cancer
- rheumatoid arthritis
- multiple sclerosis
- osteoporosis (if patient is housebound)
- pulmonary hypertension
- secondary hyperparathyroidism, and
- hepatitis C.

To find exactly which illnesses and their associated drugs are covered, and for instructions on how to apply for the program, call Medicare at 866-563-5386. You can also get information on the program through the Centers for Medicare & Medicaid Services (CMS) website at www.cms.hhs.gov (on the homepage, click “Demonstrations”).

e. Medical Equipment and Supplies

Splints, casts, prosthetic devices, body braces, heart pacemakers, corrective lenses after a cataract operation, therapeutic shoes for diabetics, and medical equipment such as ventilators, wheelchairs, and hospital beds—if prescribed by

a doctor—are all covered by Part B medical insurance. This includes glucose monitoring equipment for people who have diabetes.

f. Oral Surgery

Some types of surgery on the jaw or facial bones, or on the related nerves or blood vessels, can be covered by Part B medical insurance. However, surgery on teeth or gums, even when related to an injury or a disease that did not originate with the teeth, is usually considered to be dental work, and so is not covered by Medicare.

This is one of Medicare’s nonsensical bureaucratic distinctions. Although normal dental care is not covered by Medicare, damage to teeth or gums connected to an injury or disease is a medical as much as a dental problem. However, there is one route to coverage: If the work is done by a dentist or oral surgeon, Medicare will cover it if physicians also provide the same kind of care and if Medicare would cover the care if a doctor had provided it. This is usually determined by whether the treatment involves just the teeth and gums (not covered) or also the bones, inside mouth, blood vessels, or tongue (covered).

g. Outpatient Physical Therapy and Speech Therapy

Part B of Medicare will cover some of the cost of outpatient physical and speech therapy—if it is prescribed and regularly reviewed by a doctor and provided by a Medicare-approved facility or therapist. However, there are limits on how much Medicare will pay for these therapies. And the amount Medicare pays will be partially determined by who provides you with the services. These limits are explained in Section F4, below.

h. Home Health Care

The same home health care coverage is available under Part B medical insurance as is covered by Part A hospital insurance. (See Section C7, above, regarding home health care under Part A coverage.) There is no limit on the number of home health care visits that are covered, and you are not responsible for your Part B deductible for home health care. Only skilled nursing care or therapy while you are confined to your home is covered, however, and such care must be ordered by your doctor and provided by a Medicare-approved home health care agency.

Part B medical insurance, like Part A coverage, will pay 100% of the approved charges of a participating home health care agency. If you have both Part A and Part B, Part A will cover your home health care following a hospital stay of at least three days; otherwise, Part B will cover it.

i. Chiropractors

Part B may cover some care by a Medicare-certified chiropractor. Generally, Medicare will cover a limited number of visits to a chiropractor for manipulation of neck or back vertebrae that are out of place.

Medicare will not, however, cover general health maintenance visits to a chiropractor, nor will it usually cover therapeutic manipulation other than of the vertebrae. And Medicare generally will not cover X-rays or other diagnostic tests done by the chiropractor. Instead, your physician normally must order these tests.

If you go to a chiropractor and hope to have Medicare pay its share of the bill, have the chiropractor's office check with Medicare ahead of time about the treatment being proposed. And even if Medicare initially covers the treat-

ment, it may not do so indefinitely. So, if you continue with the treatments, have the chiropractor's office regularly check with Medicare to find out how long it will keep paying.

j. Preventive Screening Exams

Medicare covers the following examinations to screen for a number of serious illnesses:

- A one-time routine physical exam (sometimes called an "initial wellness exam") within six months of the date a person first enrolls in Part B coverage
- A Pap smear and pelvic exam every three years; every year for women at high risk of cervical or pelvic disease; Medicare covers this exam even if you have not yet met your annual Part B deductible
- Colorectal cancer screening, as your physician deems necessary
- Bone density tests for women at high risk of developing osteoporosis or for anyone receiving long-term steroid therapy, who has primary hyperparathyroidism, or who has certain vertebrate abnormalities
- Blood glucose testing supplies—if prescribed by a physician—for patients with diabetes
- Annual prostate cancer screenings for men over 55
- Annual flu shot, with no deductible and no coinsurance amount
- Positron emission tomography (PET) scans, a diagnostic test for certain cancers
- Annual eye screening for glaucoma
- Blood screening for early detection of cardiovascular disease, if your doctor says you have risk factors

- Screening test for diabetes, if your doctor says you're at risk for the disease
- PET brain scans for patients with unusual Alzheimer's-like symptoms, if your doctor believes the source may be a different type of brain disease known as "frontotemporal dementia."

k. Mammography

Part B covers a yearly mammogram, even if you have not yet met your annual deductible. The mammogram must be performed by your doctor or by a facility certified for mammography by Medicare.

l. Podiatrists

Medicare covers podiatrist services only when they consist of treatment for injuries or diseases of the foot. This does not include routine foot care or treatment of corns or calluses.

m. Optometrists

Medicare does not cover routine eye examinations, glasses, or contact lenses. The only exception is for people who have undergone cataract or other eye surgery. For them, Medicare covers glasses, contact lenses, or intraocular lenses, as well as the cost of an examination by a Medicare-certified optometrist.

n. Clinical Psychologists or Social Workers

When a doctor or hospital prescribes it in conjunction with medical treatment, Medicare Part B can cover limited counseling by a clinical psychologist or clinical social worker. The practitioner must be Medicare-approved. If your doctor suggests a clinical psychologist or social worker to help in your recovery from surgery, injury, or illness, contact the practitioner in advance to find out whether the services will be approved by Medicare.

o. Daycare Mental Health Treatment

Medicare part B can cover mental health care, in the form of day treatment—also called partial hospitalization—at a hospital outpatient department or community mental health center. The facility must be Medicare-approved and the particular day program certified for Part B coverage by Medicare.

p. Alzheimer's-Related Treatments

Until recently, Medicare did not cover various kinds of physical, speech, and occupational therapy, or psychotherapy and other mental health services, for people who had been diagnosed with Alzheimer's disease. Medicare's reasoning was that patients with Alzheimer's were incapable of medically improving, and that the treatment was therefore not "medically necessary."

Medicare has now reversed its backward stance. A patient can no longer be denied Medicare coverage for physician-prescribed therapies or treatments solely because the patient has been diagnosed with Alzheimer's. So, if you or a loved

one has Alzheimer's and a physician prescribes a form of therapy or other treatment to counter the effects of the disease, make sure the treatment provider submits its bills to Medicare for payment.

q. Obesity

Until mid-2004, Medicare had refused to recognize obesity as a disease and therefore had failed to cover any treatments for it. Now, however, Medicare has reversed its position and will cover various scientifically proven weight-loss therapies and treatments. These range from stomach surgeries to diet programs to psychological and behavior-modification counseling.

Not all treatments are covered, and not all patients will be eligible for all covered treatments. But if you are undergoing care from a physician for obesity, the physician can recommend a specific treatment for you and submit it to Medicare for coverage approval.

3. Services Not Covered by Medicare Part B

When you look at the list of what Medicare medical insurance does not cover, it's easy to understand why people with Medicare still wind up personally responsible for half of their medical bills. It also underlines the need for you to consider additional medical insurance, either through private supplemental plans, an HMO or other managed care plan, or Medicaid or Qualified Medicare Beneficiary coverage. (See Chapters 13, 14, and 15 for more on these alternatives.)

The categories of medical treatment and services listed below are not covered by Medicare.

However, the noncovered services listed below do not necessarily apply to HMO or other managed care Medicare coverage. Many managed care Medicare plans include some coverage for these medical services even though Medicare itself does not cover them. (See Chapter 14 regarding Medicare-managed care plans.)

a. Routine Physical Examinations

Regular or routine examinations are not covered by Medicare (except for an initial wellness exam, available within six months after you first enroll in Part B coverage). However, laboratory work, diagnostic testing, and physical examinations by your doctor are covered if they are part of diagnosis for a particular medical condition or complaint. Understanding the difference between these two types of physical exam—one a routine check-up, undergone simply because time has passed since a previous exam, the other to find the cause of an existing problem—can help you get Medicare coverage for medical care you might otherwise have to pay for yourself.

If something is wrong with you, Medicare will cover examinations to find out what it is, how bad it is, what the treatment should be, and how the illness and treatment are progressing. There are no rules that dictate how bad your condition must be before a doctor can examine you. And it is up to the doctor to decide what kind of an examination is necessary to find out what is ailing you—although, to be covered by Medicare, the examination must be reasonably connected to your complaint.

If your doctor decides that a physical examination and testing are necessary to find out what is wrong with you—perhaps you’ve been tired a lot, or short of breath, or having trouble sleeping, or occasionally having headaches or dizziness—and the examination and testing are medically reasonable given your physical symptoms, then Medicare is likely to cover them. On the other hand, simply complaining of mild, unspecific symptoms and then asking for a broad general physical examination does not guarantee that Medicare will pay for it.

The key is making your doctor aware that Medicare coverage of examinations can be a problem and getting the doctor to cooperate. If you need to have a check-up or physical or other general testing done, discuss the Medicare coverage question with your doctor ahead of time so he or she can make clear—both on your medical records and on the forms the doctor’s office sends to Medicare—that your examination was to find out why you had certain problems or symptoms; it was not merely a routine physical.

The following examples may give you a good idea of how paying attention to this Medicare rule about physical examinations can save quite a bit of money.

Example: Maureen was having trouble sleeping, seemed to get too many colds, and was tired a lot. She decided to get a general physical examination since she had not had one for two years. She called her doctor and asked to have a comprehensive physical examination scheduled. The doctor’s secretary asked if there was any particular problem, and Maureen said, “No, not really; I just thought it

was time to have a check-up.” When she came for the examination, she told the doctor that she was just there for a routine exam because it had been two years. She mentioned her trouble sleeping, the colds, and the tiredness, but played them down.

The doctor gave Maureen a full physical examination and took blood and urine samples for routine lab testing. Other than slight low blood sugar, nothing out of the ordinary showed up. The doctor suggested changes in Maureen’s diet, recommended some vitamins, and sent the \$380 bill to Medicare. Medicare refused to pay any of it—the doctor had reported a routine physical check-up, and Medicare reported back that it does not cover routine physical examinations.

Example: Mavis had the same vague, minor physical problems as Maureen, but Mavis was smarter about handling her doctor’s appointment. From her first conversation making the appointment through the examination itself, Mavis said she wanted to be examined for a series of specific problems: sleeplessness, a virus she could not get rid of, headaches, and dizziness—the same symptoms Maureen had. The doctor gave Mavis the same examination and lab tests that Maureen had. The results were the same, as was the prescription for vitamins and a change in diet. The doctor submitted Mavis’s \$380 bill to Medicare, and Medicare paid its share—because the doctor’s records indicated not that Mavis had been given a routine physical but that she had been examined and treated for symptoms of which she complained.

The Bias Against Preventive Medicine

Few would doubt that preventive medicine, including routine physical check-ups, can significantly reduce the number and severity of illnesses. Nevertheless, Medicare reflects the attitude of the traditional medical community, which refuses to put money or energy into public health education and disease prevention.

There are several reasons for this.

There is little or no tradition of preventive medicine in the United States, and no national, community-based public health policy or program to encourage it. In addition, since most doctors receive little training in preventive medicine, they don't stress it in their contact with patients. And finally, since medicine is run almost entirely as a business in the United States, the medical community emphasizes high-profit activities such as treatment of disease over low-profit activities such as disease prevention. This is not to say that doctors are evil, but they are part of—and most seem to be dominated by—a large medical business world, and the nature of business is profit.

In recent years, this mindset against preventive medicine has been reversed somewhat by the growth of HMOs and other managed care health plans. These plans are paid a set amount per patient, regardless of how much treatment becomes needed, and so it makes good economic sense for these plans to cut costly treatment by helping people prevent serious illness in the first place. If you have Medicare and also belong to one of these plans, you will be able to get some routine physical examinations and health screenings for free, or for minimal payments.

Medicare, too, has finally begun to acknowledge the cost benefits of preventive medicine, now covering some vaccinations, Alzheimer's treatments, and heart defibrillators for an expanded pool of patients. However, Medicare still does not cover most kinds of preventive medicine. It remains up to you to find ways to fit most preventive examinations and other screenings into the coverage Medicare does offer. (For ideas, see Subsection a, above.)

b. Treatment That Is Not Medically Necessary

Medicare will not pay for medical care that it does not consider medically necessary. This includes some elective and most cosmetic surgery, plus virtually all alternative forms of medical care such as acupuncture, acupressure, and homeopathy—with the one exception of limited use of chiropractors. (See Section E2, above, for details.) This is despite the fact that many people find these therapies more salutary than traditional forms of medical care.

c. Vaccinations and Immunizations

Most vaccinations and immunizations—such as those taken before travel abroad—are not covered by Medicare medical insurance. There is one exception for emergencies in which, for example, vaccinations or immunizations are required because of the risk of infection or because of exposure to a communicable disease. Other exceptions are made for the pneumonia vaccination, if prescribed by a doctor, and for a flu shot.

d. Drugs and Medicines at Home

This is one of the most costly areas of medical care not covered by Medicare. Part A hospital insurance covers drugs administered while you are in the hospital. And Part B medical insurance covers drugs that cannot be self-administered, which you receive while an outpatient at a hospital, clinic, or doctor's office.

But Medicare does not pay for any drugs, prescription or not, that you can administer or take yourself at home. Insulin for diabetics, for example, is a life-saving drug, but because it can be self-administered, Medicare does not cover it. The exception is the demonstration program described in "2005 Demonstration Program for Certain Self-Administered Drugs," in Section 2d, above. Under this program, up to 50,000 people will get coverage for some self-administered drugs for certain serious illness.

Prescription drugs are costly, sometimes running into the thousands of dollars each year for a person over 65. Clearly, this can eat up much of a senior's budget. See Section G, below, for ways to reduce your prescription drug costs.

e. Eyesight and Hearing Exams

Medicare medical insurance does not cover routine eye or hearing examinations. Neither does it cover hearing aids, eyeglasses, or contact lenses, except for lenses required following cataract surgery. However, if your eyes or ears are affected by an illness or injury other than simple loss of strength, examination and treatment by an ophthalmologist—an eye doctor who is an M.D.—or other physician is covered.

f. General Dental Work

Medicare does not cover work performed by a dentist or oral surgeon, unless the same work would be covered if performed by a physician. In other words, if the treatment is considered medical rather than dental, Medicare may cover it. Generally, Medicare will not cover treatment unless the problem is unrelated to normal tooth decay or gum disease, and involves either the blood vessels, nerves, or interior of the mouth, or the bones of the mouth or jaw.

F. How Much Medicare Part B Pays

When all your medical bills are added up, you will see that Medicare pays, on average, for only about half the total. Medicare gets away with this in three major ways:

First, Medicare does not cover a number of major medical expenses, such as routine physical examinations, medication, glasses, hearing aids, dentures, and a number of other costly medical services.

Second, Medicare pays only a portion of what it decides is the proper amount—called the approved charges—for medical services. In addition, when Medicare decides that a particular service is covered and determines the approved charges for it, Part B medical insurance usually pays only 80% of those approved charges; you are responsible for the remaining 20%.

Finally, the approved amount may seem reasonable to Medicare, but it is often considerably less than what the doctor actually charges. If your doctor or other medical provider does

not accept assignment of the Medicare charges, you are personally responsible for the difference.

Now that you know the worst, you can deal with the details of how much Medicare Part B pays. The rules are not hard to understand—just hard to swallow.

1. Deductible Amounts

Before Medicare pays anything under Part B medical insurance, you must pay a deductible amount of your covered medical bills for the year. The Part B deductible amount is currently \$110 per year.

Medicare keeps track of how much of the deductible you have paid in a given year. It generally does a good job of keeping track, but it is always a good idea to keep your own records and double check the accounting.

2. 80% of Approved Charges

Part B medical insurance pays only 80% of what Medicare decides is the approved charge for a particular service or treatment. You are responsible for paying the other 20% of the approved charge, called your coinsurance amount. And unless your doctor or other medical provider accepts assignment (see Section 6, below), you are also responsible for the difference between the Medicare-approved charge and the amount the doctor or other provider actually charges.



Low-income seniors may receive state help.

Under programs known as Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI), Medicare recipients who have low incomes and few assets can receive considerable help with their basic Medicare expenses.

If you qualify as a QMB, your state will pay all Medicare premiums, deductibles, and coinsurance amounts. If you qualify as an SLMB, your state will pay the monthly Medicare Part B premiums, though not deductibles or coinsurance amounts. If you meet the standards as a QI, your state will pay all or part of your monthly Medicare Part B premium, but not any deductible or coinsurance. (See Chapter 15 for a full discussion of options for low-income persons.)

3. 100% of Approved Charges for Some Services

There are several types of treatments and medical providers for which Medicare Part B pays 100% of the approved charges rather than the usual 80%, and to which the yearly \$100 deductible does not apply. In these categories, you are not required to pay the regular 20% coinsurance amount. In most of them, the provider accepts assignment of the approved charges as the full amount, so you actually pay nothing at all. With outpatient mental health care, however, Medicare Part B pays less than the usual 80% of approved charges.

a. Home Health Care

Whether you receive home health care under Part A or Part B, Medicare pays 100% of the charges, and you are not responsible for your yearly deductible. However, if you receive medical equipment—wheelchair, chair lift, special bed—from the home health care agency, you must pay the 20% coinsurance amount.

b. Clinical Laboratory Services

Medicare pays 100% of its approved amount for such laboratory services as blood tests, urinalyses, and biopsies. And the laboratory must accept assignment, except in Maryland where a hospital lab can bill you, as an outpatient, for a 20% coinsurance amount.

c. Flu and Pneumonia Vaccines

Medicare pays the full 100% of its approved charges for these vaccinations, and the \$100 yearly deductible does not apply. However, the provider is not required to accept assignment, so there may be an additional 15% charge on top of the amount Medicare approves.

d. Outpatient Mental Health Treatment

For mental health services provided on an outpatient basis, Part B pays only 50% of approved charges. This is true whether the services are provided by a physician, clinical psychologist, or clinical social worker at a hospital, nursing facility, mental health center, or rehabilitation facility. The patient is responsible for the yearly

deductible, for the unpaid 50% of the Medicare approved amount, and, if the provider does not accept assignment (as described in Section 6, below), for the rest of the bill above the Medicare-approved amount, up to an additional 15%.

4. Payments for Outpatient Therapies

How much Medicare pays for outpatient physical therapy (PT), speech-language therapy (SLP), and occupational therapy (OT) depends on where you receive the therapy.

Therapy received in a doctor's or therapist's office, a rehabilitation facility, or a skilled nursing facility while you're an inpatient. Medicare will pay 80% of the Medicare-approved amount. You or your supplemental insurance or managed care plan remain responsible for the other 20%. There is no limit on the amount of therapy Medicare will cover, if it is medically necessary and prescribed by your physician.

Therapy received at home. If you receive therapy at home from a Medicare-certified home health care agency as part of a comprehensive Medicare-covered home health care program, Medicare will pay 100% of the cost. If you receive therapy at home that is not part of a Medicare-covered comprehensive home health care plan, Medicare will pay 80% of approved charges.

Therapy received at a hospital outpatient department. Medicare will pay 100% of the Medicare-approved amount. However, hospital outpatient departments are not required by law to accept the Medicare-approved amount as the full charge for their services. Instead, they

can bill you personally for any amounts above the Medicare-approved amount. You may want to see whether there is a local hospital for your therapy that will accept “assignment” of the Medicare-approved amount as the total amount of its bill. (For a full explanation of “assignment,” see Section 6, below.)

5. Legal Limit on Amounts Charged

By law, a doctor or other medical provider can bill you no more than what is called the “limiting charge,” which is set at 15% more than the amount Medicare decides is the approved charge for a treatment or service. That means you may be personally responsible—either out of pocket or through supplemental insurance—for the 20% of the approved charges Medicare does not pay, plus any amount the doctor charges up to the 15% limiting charge. Regardless of how much the doctor or other medical provider charges non-Medicare patients for the same service, you can be charged no more than 15% over the amount Medicare approves.

States With Limits on Balance Billing

Several states—Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, and Vermont—have passed balance billing or charge-limit laws. These laws forbid a doctor from billing patients for the balance of the bill above the amount Medicare approves. The patient is still responsible for the 20% of the approved charge not paid by Medicare Part B.

The specifics of these patient protection laws vary from state to state: Some forbid balance billing to any Medicare patient, others apply the restriction only to patients with limited incomes or assets. To find out the rules in your state, call the following agencies:

- Connecticut Medicare Assignment Program (Conn MAP): 800-443-9946
- Massachusetts Executive Office of Elder Affairs: 800-882-2003, 617-727-7750
- Minnesota Board on Aging, Ombudsman for Elder Minnesotans: 800-657-3591
- New York State Office for the Aging: 800-342-9871
- Ohio Department of Aging: 800-899-7127
- Pennsylvania Department of Aging: 717-783-1550
- Rhode Island Department of Elderly Affairs: 401-222-2858
- Vermont Department of Aging & Disabilities: 801-241-2400.

6. Assignment of Medicare-Approved Amount

In most instances, Medicare pays 80% of the approved amount of doctor bills; you or your private insurance pay the remaining 20%. However, you can avoid having to pay anything above the Medicare-approved amount if your doctor accepts assignment of that amount as the full amount of your bill.

Most doctors who treat Medicare patients will accept assignment. Some have signed up in advance with Medicare, agreeing to accept assignment on all Medicare patients. They are called Medicare participating doctors and are paid slightly higher amounts by Medicare than nonparticipating doctors. Others have not agreed to accept assignment on all patients but will do so on some or most claims.

Unfortunately, many doctors—particularly specialists who have to compete less for patients—still do not accept assignment at all. When deciding on a doctor, find out in advance whether the doctor always takes assignment of the Medicare-approved amount, or if he or she is willing to take assignment on your bills.



Treating doctors must accept assignment for Medicaid and QMB patients. If you receive Medicaid assistance (called Medi-Cal in California) as well as Medicare, or are a Qualified Medicare Beneficiary (QMB), federal law requires that a doctor who agrees to treat you must also accept assignment. (See Chapter 15 for more on the Medicaid and QMB programs.)

7. No Limit on Outpatient Hospital Charges

Hospitals have more leeway than doctors when it comes to charging patients on Medicare. If you receive outpatient services at a hospital, you are responsible not simply for 20% of the amount Medicare approves, but for 20% of whatever amount the hospital decides to charge you. And that total amount is not limited in any way by the Medicare-approved amount, as are doctors' fees.



Two helpful links for information on keeping down your medical costs are on the Medicare website at www.medicare.gov. The first, called “Participating Physician Directory,” will tell you which doctors and specialists in your area will accept assignment on Medicare-covered services. You’ll find this link right on the home page. However, it’s best to phone the physician’s office to double check the information before making any firm plans.

Also on the home page, you’ll find a “Supplier Directory” link. This takes you to a list, by geographic area, of suppliers of medical equipment, prosthetics, and orthotics that accept Medicare’s approved amount as a limit on what they charge you.

Beware of Huge Outpatient Hospital Bills

Because there is no limit on how much hospitals can charge Medicare patients for outpatient services, hospitals are now trying to make as much money as possible from outpatients.

They do this in two ways: First, they try to have Medicare patients receive treatment on an outpatient rather than inpatient basis—even if it would be medically good practice, and the physician involved would prefer, to have the patient treated in a hospital. Second, hospitals jack up to astronomical levels the cost of outpatient services, because they know they can bill the patient for 20% of the full amount.

The result of this loophole in the Medicare law is that hospitals have been sticking Medicare patients for almost 40% of total payments for outpatient costs. For outpatient surgery, radiology, and other diagnostic services, patients are winding up responsible for about 50% of total payments to hospitals. And over the next few years, hospitals are expected to raise their outpatient charges so high that the patient's portion of the payment is expected to reach a staggering 70%.

There are several ways to try to combat hospital practices of overcharging for outpatient services. First, before you receive an outpatient service, check with the hospital administrator or financial office personnel to see if the hospital will accept the Medicare-approved amount as the total bill—meaning you or your private insurance would be responsible for only 20% of that approved amount.

If not, ask your doctor if the service can be performed either in the doctor's office or at an independent laboratory instead of at the hospital. If the service can be performed only at a hospital, explain the Medicare payment problem to the doctor and ask if there is another hospital where you might receive the services and which would charge only the Medicare-approved amount.

Finally, if you cannot find a way to receive the outpatient services at a Medicare-controlled cost, you might want to push to receive the service or treatment as an inpatient. Of course, inpatient treatment would have to be medically defensible, and many services simply do not justify an inpatient stay. But other treatments may be performed either as inpatient or outpatient services. And while hospitals are trying to force people to receive these services only as outpatients—a nonradical mastectomy is a recent example—a doctor can usually put pressure on the hospital to permit you to receive the service as an inpatient.

Ask your doctor if the treatment or service you are to receive as an outpatient might instead justify that you go into the hospital for an overnight stay. If so, you would be responsible for only the yearly inpatient deductible, which might be considerably less than what you would owe as an outpatient. And if you have already paid your hospital deductible for the current benefit period, you might not owe anything at all.

Private Fee-for-Service Plans Outside Medicare

Some businesses, unions, and other organizations offer general health insurance plans—either during employment or after retirement—that accept people eligible for Medicare. A private health insurance plan that accepts Medicare enrollees must offer at least as much coverage as basic Medicare would provide, and most of these plans provide more than that.

If you choose to join or remain with such a health plan once you become eligible for Medicare, the plan—and not Medicare—will make all decisions about coverage for specific services and the amount of payment.

You may be responsible for plan premiums and copayments, as well as the difference between what the plan pays the provider and what the provider actually charges. Unlike with regular Medicare, there is no legal limit on the amount a provider may charge you above what the insurance pays.

G. Help With Prescription Drug Costs

If you've taken any prescription medications lately, you've no doubt noticed that prices have shot through the roof. Older people suffer disproportionately from these exorbitant prices, because they are the ones using the most medications, and spending the highest proportion of their incomes on drugs, relative to the rest of the population. Here in the richest country in the world, many people must choose between taking their medicine and eating.

After years of failing to address this scandalous situation, the end of 2003 brought some Congressional action. A provision was added to the Medicare plan offering recipients the option to buy outpatient prescription drug coverage (at an added monthly premium). When the new law goes into effect in 2006, Medicare prescription drug insurance will pay for only a portion of prescription medication costs, leaving seniors to pay the rest. The new law will do nothing to control the skyrocketing overall cost of prescription drugs.

Until 2006, when the new law goes into effect, Medicare beneficiaries seeking to control costs will have to negotiate a patchwork of public and private plans and programs. By doing your research, however, you may be able to access free or discounted prescription medications. The plans and programs of potential interest to you include:

- **Medicare drug discount cards.** This is a temporary, stopgap program of prescription drug discount cards available from mid-2004 through the end of 2005. It was created in an effort to blunt criticism regarding the new Medicare drug coverage that will go into effect in 2006, which offered seniors no immediate help with prescription drugs costs. The discount cards are available to anyone with Part B Medicare coverage, to reduce their drug costs. In addition, people with low incomes can get up to \$600 per year in credits toward the purchase of prescription drugs through this program. (See Section 1, below.)
- **Private health insurance.** Some medigap Medicare supplement policies and managed care plans provide a certain amount of prescription drug coverage. (See Section 2, below.)

- **Government programs.** Many states and some local communities have programs that help people pay for medications. Also, the Department of Veterans Affairs (VA) provides free or discounted drugs to qualifying veterans. (See Section 3, below.)
- **Pharmaceutical company discounts.** Under pressure from consumer groups, and hoping to forestall government intervention regarding their price gouging, some drug companies offer small discounts on certain of their prescription medicines for Medicare patients, particularly those with low incomes. (See Section 4, below.)

For how to find government assistance programs in your state and community, as well as how to find out whether a pharmaceutical company discount is available for medications you are taking, see Section 5, below.

I. Medicare Drug Discount Cards

Medicare drug discount cards will be temporarily available from mid-2004 to the end of 2005. Under the Medicare Modernization Act of 2003, these cards are to be replaced at the beginning of 2006 by new Medicare prescription drug coverage.

Most people enrolled in either Part A or B of Medicare are also eligible to enroll in one, but only one, Medicare drug discount card program. There is also a special provision for low-income Medicare enrollees—if they qualify, they get a credit worth \$600 in covered prescription drugs.

a. Who Runs the Program

These discount cards are not offered by Medicare itself. Instead, Medicare certifies private commercial companies and nonprofit organizations to run individual drug discount card programs. These programs negotiate with pharmaceutical companies to purchase prescription medications in bulk at a discount, then turn around and sell them at somewhat less than regular retail prices to consumers who have signed up for that program's card. Some programs are available throughout the country. Others are available only in particular geographic regions.

b. How Much You'll Save

Medicare drug discount cards offer people an average savings of 10%–15% off regular retail prices. However, the amount any one person might save depends on a whole host of factors, including the number and type of medications the person takes and the discount on those drugs offered by the plans available where that person lives. Other savings programs discussed later in this chapter may actually offer better discounts on specific drugs than a Medicare drug discount card.

c. Who Can Enroll in a Discount Card Program

Most people with Medicare coverage may enroll in any Medicare drug discount card program available where they live. But there are a few restrictions:

- You can enroll in only one Medicare drug discount card program at a time.

- You may not enroll in the program if you already have outpatient prescription drug benefits through Medicaid (also called Medical Assistance, and Medi-Cal in California).
- If you are enrolled in a Medicare managed care plan that offers a Medicare drug discount card only to its members, you may enroll only in that discount card program. However, if your managed care plan offers no Medicare drug discount card, or offers its card to people who are not members of the plan, then you are free to choose any drug discount card program available where you live.
- Low-income people who qualify for the special \$600 credit will face further restrictions, as discussed in Subsection f, below.

Notice that many of these restrictions forbid doubling up on prescription drug coverage. However, there is no restriction on enrollment if you receive drug discounts through a state pharmacy assistance program, a medigap or other supplemental health insurance policy, or a pharmaceutical company, retail pharmacy chain, or other non-Medicaid discount program.



Your Medicare managed care plan may have already enrolled you. If you belong to one of the Medicare managed care plans that offers a drug discount card, that plan may have already signed you up for its card. They are allowed to do so because, under the Medicare rules, your membership in such a plan means you are not allowed to enroll in any other Medicare drug discount card program anyway.

d. Different Cards Offer Different Discounts

It's important to shop around when choosing a drug discount card—the discounts are not standardized, nor across the board. Every company or organization that offers a drug discount card must first negotiate deals with the various pharmaceutical companies. Assuming the company that offers the card negotiates a low purchase price for drugs, it can then turn around and sell the drugs to cardholders at a discount. The result, however, is that different discount card companies offer a different list of discounted drugs—some brand names, some generics. Also be aware that some programs charge an enrollment fee, of up to \$30.

Your best bet is to find a Medicare drug discount card program that sells one or more of the medicines you're now taking, at less than you currently pay. The more of your medicines a particular program sells at discount, and the higher those discounts, the better that program is for you.



Drug prices may change at any time. Unfortunately, your card doesn't come with price guarantees. Medicare drug discount card programs are allowed to change their prices every month, and many of them do—particularly when the pharmaceutical companies change their prices, or when the discount card program believes it can get away with charging a higher price.

Another factor in choosing a drug discount card is whether the offering company makes it easy for you to get your prescriptions filled.

Some offer medicines only through the mail. Others permit you to buy the drugs only at a very limited number of pharmacies. And some permit you to buy your medicine at certain chain pharmacies but not at others.



Don't feel you have to buy all your drugs using the card. Keep shopping around—even if your drug discount card saves you a lot on one or two of your medicines, you may get a better price on your other drugs through a pharmacy, a pharmaceutical company, state assistance, or another discount program. You are free to buy other medicines from any other source except Medicaid or Medi-Cal. And if your Medicare drug discount card company raises its price for one of your drugs, make sure to check with the other programs to see whether you can get a better deal there.

e. Get Organized About Comparing Drug Discount Card Programs

The best way to choose the discount program that best serves your needs is to do a little organized homework, as follows:

Step 1. Make a list of all the prescription medications you take regularly. Then figure out how much each of these costs you, per prescription.

Step 2. Find out what Medicare drug discount card programs are available where you live. This information is available on the Medicare website at www.medicare.gov (click “Prescription Drug and Other Assistance Programs”).

You'll be asked to fill out a simple electronic form. You will then be shown a list of the programs available in your geographic area, including basic information like which common drugs the program covers, what the enrollment fee is, how enrollees can obtain their medicine, and how to contact them. Alternatively, the same information is available by calling Medicare at 800-MEDICARE (800-633-4227).

Step 3. If you find a program available in your area that covers some or all of the medicines you take, contact that program directly to find out for certain:

- which of your prescription medicines are covered
- how much the program charges for each covered medicine
- the enrollment fee, if any
- whether a local pharmacy accepts the card or you must travel farther to get it
- whether the medicines are available by mail, and if so whether the cost is different from buying at a pharmacy, and
- whether you can use the card if you travel to another state.

Step 4. Compare the fees and prices under each program with what you're paying now for your medications. If one or more of the programs offers a better bargain, decide which card offers the best one. Also consider how convenient it is for you to get your drugs under each program.

For help with this process, contact the local office of your State Health Insurance Assistance Program (SHIP). (For state contact information, see Chapter 12, Section G.)

Unfortunately, once you choose a particular Medicare drug discount card, you are stuck with that card even if it raises its prices, except in the limited circumstances explained in Subsection h, below. (Remember, though, that you are still free to look for a better price under non-Medicare sponsored discount programs.)

f. Special Benefits for People With Low Incomes

Medicare offers a special program for low-income seniors, giving them up to \$600 in credit toward the purchase of prescription drugs every year, and paying any enrollment fee charged by a Medicare prescription drug discount card program.

To qualify for this special credit, your total income from all sources must be no more than \$12,569 if you are single, and \$16,862 for both you and your spouse if you are married. When adding up your income, Medicare counts your Social Security or other retirement or disability benefits, and anything else that would be considered income for tax purposes. However, your assets are not considered in determining your eligibility, only your income.

You may not qualify for the credit if you already have prescription drug coverage through:

- Medicaid (Medi-Cal)
- an employer group health plan or retiree health coverage other than a Medicare Advantage (formerly Medicare + Choice) plan or medigap policy
- TRICARE for Life military health insurance
- FEHBP health insurance for federal employees and retirees, or

- certain Medicare managed care plans (“cost”-based plans) that offer their own drug discount card to members—check with your plan to see whether you are eligible.

Not everyone will get the full \$600 worth of credit. The amount of credit you receive, if you qualify, depends on when you apply. If you first qualify in 2004, you may be entitled to \$600 in credit for the remainder of 2004, and another \$600 in 2005. Any part of the \$600 for 2004 that you did not spend in that year carries over to 2005, in addition to the \$600 you have for 2005. If you first apply for credit in 2005, the amount you may receive depends on the specific date you apply, as follows:

January 1–March 31, 2005—\$600 credit

April 1–June 30, 2005—\$450 credit

July 1–September 30, 2005—\$300 credit

October 1–December 31, 2005—\$150 credit.

The amount of your credit will be applied to your discount card. Each time you buy a prescription using your card, the price will be subtracted from your total credit. You will, however, have to pay a small coinsurance amount of 10% (only 5% if your income is less than \$9,310, or less than \$12,490 for a couple) of the discount price. The pharmacy receipt or statement you get with each prescription will tell you how much of your credit you have left. If and when you use up your credit, you will still be able to buy medicine at the discount price when you use your card.

g. Enrolling in a Medicare Drug Discount Card Program

To enroll in a particular Medicare discount drug card program, contact the program itself, not

Medicare. You may be able to enroll over the phone, or on the program's website. Or, the program will mail you a simple written form to fill out and return to them.

If you are applying for the \$600 low-income credit from Medicare, you will have to fill out a slightly longer written application form, which the discount card program will send you.

h. Changing Discount Card Programs

If you had a Medicare drug discount card during 2004, you are allowed to switch to a new Medicare drug discount card program in 2005. Otherwise, you are not allowed to switch from one Medicare drug discount card program to another unless you meet one of the following conditions:

- you move to a state in which your current discount card is not valid
- you join or leave a Medicare Managed Care Plan that offers its own drug discount card
- you enter or leave a long-term care facility (nursing facility, board-and-care home, or the like), or
- the company that runs your Medicare drug discount card program ends the program.

In any of these situations, you may choose a new card, but you will have to pay a new enrollment fee if the program you choose requires one.

2. Private Health Insurance Drug Coverage

A few medigap Medicare supplementary private insurance policies provide limited coverage for prescription drug costs. Most Medicare managed care plans also provide some drug coverage.

a. Medigap Policies

Many people get help with the various costs that Medicare won't cover by buying a form of private, supplemental health insurance known as medigap insurance. The terms and conditions of these policies are tied to Medicare coverage. Also, the federal government has established minimum standards that medigap insurers must meet. You won't find coverage of prescription drugs in all standard medigap policies, but it is available in the three most expensive ones. Medigap policies and their drug coverage are explained in detail in Chapter 13.

b. Managed Care Plans

Many people receive their Medicare coverage through a private managed care health plan, usually a health maintenance organization (HMO). One of the attractions of managed care plans is that they usually include some prescription drug benefits. Most plans cover some—but not all—prescription drugs and require the patient to pay a flat copayment. The list of covered drugs can sometimes seem frustratingly narrow, and the plans greatly favor generic over name-brand medicines. Medicare managed care plans and their drug coverage are explained in detail in Chapter 14.

3. Government Programs Providing Drug Coverage

A number of individual U.S. states have created programs to provide discounts on prescription medications to Medicare patients. Also, the Department of Veterans Affairs (VA) offers free or low-cost drugs as part of its overall health care system for veterans.

a. State and Community Assistance Programs

It's worth finding out whether your state is one of the many that assist Medicare patients in paying for prescription drugs. Some states' programs offer across-the-board discounts on all drugs, while others provide only limited discounts on certain drugs. Some programs offer special tax credits for prescription drug costs. Some limit their prescription drug assistance to lower-income seniors.

Local community-based programs also sometimes provide free or discounted drugs to low-income seniors.

To learn whether your state or local community has a drug discount program and how to qualify for it, see Section 4, below.

b. Veterans Benefits

If you are a veteran, you may be eligible for free or low-cost medical treatment by Veterans Affairs health providers. If so, you'll receive prescription drugs either at low cost (assuming they're prescribed by a VA doctor) or for free, if you're disabled or low income.

That means that even if you normally see a civilian doctor and use Medicare to cover your care, you might want to see a VA doctor to get a prescription for medication that would be expensive if you had to pay for it out of pocket or that you'll be taking for a long time. (For a discussion of medical benefits for veterans, see Chapter 10.)

4. Free and Discounted Drugs

There are both informal and formal ways to obtain drugs from pharmaceutical companies for free or at a discount. For the free medications, see whether your doctor can occasionally provide you with samples (as described in Subsection a, below). Also ask your doctor to help you take advantage of discount programs offered by the pharmaceutical companies (as described in Subsection b, below). You may also be able to get help from nonprofit and retail drug clearinghouses (described in Subsection c, below).

a. Physician Samples

In an effort to push their particular brand of drugs, pharmaceutical companies send free samples to doctors. The doctors, in turn, may distribute these drugs free to patients. If your doctor prescribes a medication for you, ask whether the doctor has any free samples you might use. Unfortunately, while this can eliminate the cost of medications for a one-time, short-term condition, doctors do not normally have enough samples to fill your long-term needs.

b. Pharmaceutical Company Discount Programs

Facing pressure from consumer groups and organizations of seniors, some pharmaceutical companies have begun to offer discounts on certain medicines for some Medicare patients. Most of these programs are available only for low-income seniors who have no other drug coverage (such as through private insurance or a managed care plan). The companies do not necessarily offer discounts on every drug they manufacture. Also, the discounts tend not to be very generous. Nevertheless, if you frequently take a particular medication, even a small discount can add up to a significant savings over time.

In order to participate in one of these programs, you have to register with the pharmaceutical company. The doctor who prescribes the medication for you usually has to fill out enrollment papers for you, too. Some of these programs provide free or discounted drugs only to doctors, who then distribute them to the patient. To find out whether there is such a program for a medicine you regularly take, and how to register for it, see Section 5, below.

c. Nonprofit and Retail Discount Programs

A number of nonprofit and retail organizations (including a number of large drugstore and supermarket chains) have developed programs to provide discounted prescription drug medications, particularly to seniors. These organizations use their ability to purchase in large quantities to talk drug companies into offering some discounts. The organizations then pass these savings along to their members. There is usually

a membership fee and a copayment or processing fee for each medicine you order. Customers are sometimes given a “discount card” to facilitate their use of the program.

The discounts, however, are not always very substantial, are not available for all drugs, and are cut into by enrollment and processing fees. Also, the discounts are not honored at all pharmacies, so you may have to shop at a pharmacy whose overall prices are higher before you can use your discount.

As a result, savings from these cards and other programs average less than 10%. For an expensive drug that you’ll be taking over a long period of time, however, that can still amount to a substantial savings. To find out about participating in such programs, see Section 5, below.

5. How to Find Programs Where You Live

This section explores the many resources for finding out about drug discount programs available in your area offered by the government, pharmaceutical companies, or nonprofit organizations. Once you locate a program for which you might be eligible, you or your doctor will normally have to contact the program directly in order to enroll.

a. Information From Medicare

Medicare itself can direct you to many of the governmental and nongovernmental programs available to help you (including Medicare’s own drug discount cards, discussed in Section 1, above). One source for Medicare information is

Buying Medications From Canada

The exact same prescription drugs for which we pay exorbitant prices in the United States are available for far less in Canada. That is because, unlike the United States, Canada has a comprehensive public health care system. And that system negotiates with pharmaceutical companies, most of them in the U.S., over the price of their prescription drugs. The pharmaceutical companies willingly and profitably sell their products in Canada, even at these much lower prices.

Why can't the Medicare system do the same price negotiating? Medicare would have even more bargaining power—with 40 million enrollees (most of whom use prescription medications), its customer base exceeds the entire population of Canada (only 32 million, including children and adults under 65, who tend to use many fewer medicines).

But the U.S. government continues to favor unrestrained pharmaceutical company profits over affordable medicines for its older population. One of the least publicized parts of the Medicare Modernization Act of 2003 is that it actually forbids Medicare from negotiating for bulk-purchase lower prices from pharmaceutical companies. This is nothing less than a sellout to the pharmaceutical industry behind the backs, and out of the wallets, of older Americans.

Getting drugs from Canada. Many Medicare recipients have, in recent years, found it worth their trouble to buy medicine from pharmacies in Canada. Some do so through mail order or online prescription drug outlets. Others physically cross the border to buy their medicine at Canadian health clinics and pharmacies.

In the seemingly endless quest to protect drug company profits, the U.S. Federal Drug Administration (FDA) has tried to close down the U.S.-based outlets that supply Canadian drugs. But consumers will not be easily stopped, and are placing great pressure on Congress to pass a law permitting the legal direct importation of drugs from Canada. Also, a number of state govern-

ments are developing programs to help their residents obtain drugs from Canada as soon as the FDA rescinds its protectionist rule.

Although the law has not yet been changed to permit direct importation, a number of ways remain to get less expensive medications from Canada. If you live in a state that borders Canada, you may be able to travel there on one of the "RxExpress" bus trips organized by the nonprofit Alliance for Retired Americans. For details, and to keep abreast of developments concerning Canadian drug importation, see the Alliance's website at www.retiredamericans.org, or call them at 888-373-6497.

Unique opportunities in Illinois, Wisconsin, and Missouri. The state governments of Illinois, Wisconsin, and Missouri, under pressure from consumer groups, have decided to defy the FDA by sponsoring a program to help residents of those states buy much cheaper prescription drugs from Canada, Ireland, and the United Kingdom. (It remains to be seen whether the FDA will go to court to try to block the program.) This program, called I-SaveRx, connects patients with a drug clearinghouse in Canada, which in turn provides the medications at a 25%–50% discount off U.S. retail prices. So far, about 100 brand-name medications taken for chronic or long-term conditions are included. To find out more about this program, see www.i-saverx.net, or contact a local SHIP office in either state. (Central SHIP office phone numbers are listed in Chapter 12, Section G.)

Other services providing medicines from Canadian pharmacies can be found by searching the Internet, for example, using the search term "prescription drugs Canada." However, before using any online Canadian drug outlet, ask people at your local senior center, a counselor at your local State Health Insurance Assistance Program (SHIP), or others about their impression of the outlet's reliability and quality.

its website at www.medicare.gov. On the home page, you'll find a link for "Prescription Drug and Other Assistance Programs." You'll be asked for some personal information—which will be kept strictly confidential—in order to determine which programs you might be eligible for. The site then directs you to your state's prescription drug assistance program and to any community-based programs in your area. And based on any specific drug you mention, you'll also be directed to pharmaceutical company discounts that may be available for that drug. Finally, the Medicare website lists contact information for some of the nonprofit and retail organizations that offer drug discount cards and similar plans, and explains their basic benefits and eligibility rules.

Alternately, you can call Medicare's toll-free line at 800-MEDICARE and ask about prescription drug assistance programs.

b. State Health Insurance Assistance Program (SHIP)

Every state has a program that provides free assistance to people who have questions or problems concerning Medicare, Medicaid, health insurance, and related matters. This program is usually called the State Health Insurance Assistance Program (SHIP). In some states the program is called the Health Insurance Counseling and Advocacy Program (HICAP), in other states something similar.

SHIP maintains local offices with trained counselors. Among other things, these counselors can help you learn about prescription drug assistance programs available where you live, including Medicare drug discount cards. They

can also help you with any enrollment procedures.

For more about SHIP, see "State Health Insurance Assistance Programs (SHIP)" and the list of state SHIP phone numbers in Chapter 12, Section G.

c. Area Agency on Aging

Area Agency on Aging is a federal government clearinghouse for information about issues relating to seniors. One of their local offices can provide you with information about your state's assistance program and about any community-based drug assistance programs near you. To find the closest Area Agency on Aging office, call its toll-free line at 800-677-1116 or go to its website at www.eldercare.gov.

d. Drug Discount Information Clearinghouses

A number of information clearinghouses, most of them Web-based, will tell you about drug assistance and drug discount card and similar programs. Here are some of these clearinghouses and the information they offer:

- PhRMA (Pharmaceutical Research and Manufacturers of America), at www.phrma.org. This nonprofit foundation keeps a list of pharmaceutical companies providing free prescription drugs to patients who cannot afford them. The programs do not send medicine directly to patients, but only to doctors, who then distribute them to needy patients. A doctor and patient must jointly apply for the drugs. PhRMA also maintains

another website to help patients identify the programs for which they might be eligible and to manage the application process; see www.helpingpatients.org.

- TheMedicineProgram, at www.themedicineprogram.com or 573-996-7300 (in Doniphan, Missouri). This organization helps patients navigate the various drug assistance programs available through the PhRMA (see above). It identifies which programs a patient might be eligible for and

provides a packet of forms and information to help patients and their doctors apply for free medication.

- Volunteers in Health Care, at www.rxassist.org. This nonprofit organization's website provides both direct links to pharmaceutical company drug assistance programs, and information about other websites and organizations that can help you apply for assistance. These include links to nonprofit and retail drug discount cards and similar programs.





Medicare Procedures: Enrollment, Claims, and Appeals

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Chapter 11 described the eligibility for Medicare. As you'll remember, most people are eligible for Part A hospital insurance free of charge; if you are not, you may enroll by paying a monthly premium. Part B medical insurance coverage is available to most people age 65 and older, and everyone covered pays a monthly premium for it.

This chapter explains how to enroll in Medicare Part A and Part B. (See Sections A and B.) It also explains how to get Medicare to pay its share of your medical bills once you are enrolled. (See Section C.) It shows what portion of the bill you must pay yourself. (See Section D.) And it includes an explanation of how to read the notice Medicare sends you. (See Section E.) Finally, it explains how to appeal a Medicare decision regarding your claim. (See Section F.)

A. Enrolling in Part A Hospital Insurance

Medicare Part A, also called hospital insurance, covers most of the cost of inpatient care in a hospital or skilled nursing facility, and also the costs of home health care. Most people 65 or older are eligible for Part A coverage. Some will receive it automatically and free of charge, along with their Social Security benefits. Others will need to enroll and possibly pay a monthly fee.

I. Those Who Receive Social Security Benefits

If you are already receiving Social Security retirement, dependents, or survivors benefits or Railroad Retirement benefits, before you turn age 65, you don't need to do any paperwork to enroll in Medicare Part A hospital insurance. Social Security will automatically enroll you, and coverage will take effect on your 65th birthday. About three months before your 65th birthday, Medicare will mail you a Medicare card and information sheet.

Likewise, if you receive Social Security disability benefits for two years, regardless of your age, you will be automatically enrolled in Medicare Part A, effective 24 months from the date Social Security declared that your disability began. The Medicare card you receive in the mail will indicate that you are enrolled in both Part A and Part B. If you do not want to be enrolled in, and pay the monthly premium for, Part B, there is a form for you to sign and return to Medicare. If you do want to be enrolled in both Parts A and B, you don't have to do anything. Just sign your card and keep it handy.

If you are receiving Social Security benefits but do not receive your Medicare card in the mail within a month of your 65th birthday, or within a month of your 24th month of disability benefits, contact your local Social Security office or call the national Social Security office at 800-772-1213.

Managed Care Plans Handle Medicare Paperwork

Many people about to qualify for Medicare have HMO or other managed care insurance that they intend to keep when they become eligible for Medicare. Other people decide to join an HMO or other managed care plan when they first become eligible for Medicare.

If you intend to remain with your current insurance plan when you become eligible, it can sign you up for Medicare and switch you to the plan's Medicare coverage. Begin this process two to three months before you become eligible for Medicare.

Similarly, if you decide to join a managed care plan for the first time when you become eligible for Medicare, you can sign up for Medicare at the same time you sign up for the plan. Try to get the paperwork started at least two months before your Medicare eligibility begins.

Your Medicare Card

When you are enrolled in Medicare, you will be sent a Medicare card that states:

- your name
- whether you have both Part A and Part B coverage or just Part A
- the effective date of your Medicare coverage, and
- your health insurance claim number—also called your Medicare number—which consists of your Social Security number and one or two letters.

Always carry your Medicare card with you. You will be asked to present it when you seek medical treatment at a hospital, doctor's office, or other health care provider.

Also, you must include your Medicare number on all payments of Medicare premiums or correspondence about Medicare.

If you lose your Medicare card, you can have it replaced by applying in person at your local Social Security office or by calling the toll-free information line at 800-MEDICARE, or Social Security's main office at 800-772-1213. Alternatively, you can apply for a new card online at www.medicare.gov.

2. Those Who Do Not Receive Social Security Benefits

If you are soon to turn 65 but you are not receiving Social Security retirement, dependents, or survivors benefits; Railroad Retirement benefits; or federal civil service retirement benefits, you must apply at your local Social Security office to receive Medicare Part A benefits. If you are going to apply for retirement or other Social Security benefits to begin on your 65th birthday, you can apply for Medicare at the same time, at your local Social Security office.

a. Who Is Eligible

If you are eligible for Social Security benefits, you can receive free Medicare Part A coverage at age 65 whether or not you actually claim your Social Security benefits.

For example, many people who continue working after reaching age 65 do not claim retirement benefits until later. Still, they can receive free Part A Medicare coverage by applying for it at their local Social Security office.

Also, if you are not automatically eligible for free Part A coverage, you may be able to purchase it for a monthly premium. The amount of the premium depends on how many work credits you or your spouse has earned. (See Chapter 11, Section C1, for details.)

b. When to Apply

Whether you wish to claim Social Security benefits and Medicare, or just Medicare, apply well before you turn 65. You can apply as early as three months before your 65th birthday.

Signing up early is important for two reasons: First, it will ensure that your coverage begins as soon as you are eligible, on your 65th birthday. Second, if you wait more than three months after your 65th birthday to enroll, you will not be allowed to enroll in Part B until the following January 1, and your eligibility will not begin until July 1 of that year. (See Section B3, below, regarding delayed enrollment.)



Avoid delays in Part B coverage. If you do not enroll in both Part A and B during your initial enrollment period, your enrollment in Part B will not only be delayed, but you will also have to pay a higher monthly premium for it. (See Section B3, below, for details.)

c. When Benefits Begin

If you apply for Part A of Medicare within six months after you turn 65, your coverage will date back to your 65th birthday. But if you apply after that, your coverage will date back only up to six months from the month in which you applied. If your Medicare eligibility is based on disability, however, your coverage will date back up to one year from the date on which you apply.

3. Appealing Denial of Coverage

Eligibility for coverage by Part A of Medicare depends solely on your age and on the number of Social Security work credits you or your spouse have acquired. (See Chapter 11, Section C, for a review of the eligibility requirements.) You can be denied coverage by Medicare Part A only if there is a dispute about whether you have reached 65, about the number of your or your spouse's work credits, or about the validity of your marriage.

Decisions about these matters are handled not by Medicare but by Social Security. And, like any other decision of the Social Security Administration, a decision denying eligibility for Medicare Part A hospital insurance coverage can be appealed. The appeal process is the same as for appealing other Social Security decisions. (See Chapter 8 regarding appeals procedures.)

B. Enrolling in Part B Medical Insurance

Medicare Part B, referred to as medical insurance, covers doctors' services plus laboratory, clinic, home therapy, and other medical services you receive other than when you are a patient in a hospital or skilled nursing facility. Most people age 65 are eligible for Part B.

Everyone must pay a monthly premium to enroll, although some people may pay for Part B fees in the premiums they pay to HMOs or other managed care plans.

This section explains who is automatically enrolled in Part B, who must take steps to enroll, and when to do so.

1. Those Who Receive Social Security Benefits

If you are under age 65 and already receiving Social Security retirement, Railroad Retirement, dependents, or survivors benefits, you will be automatically enrolled in both Medicare Part A and Part B within three months of turning 65. Your coverage will become effective on your 65th birthday. Near that time, you will be sent your Medicare card through the mail, along with an information packet. The monthly premium for Part B coverage will be deducted automatically from your Social Security check, beginning with the first month after your 65th birthday.

If you do not want Medicare Part B coverage—perhaps because you are still working and are covered by an employment-related health plan—notify Social Security of that fact on the form that comes with your Medicare card. If you reject Part B coverage when you are first eligible for it, you can enroll in Part B later on, although only during the first three months of any year. And if you enroll later, your premiums may be higher.

2. Those Who Do Not Receive Social Security Benefits

If you are turning 65 but are not eligible for Social Security benefits, or are not yet going to claim benefits to which you are entitled, you may still enroll in Part B medical insurance at your local Social Security office.

You can enroll during an initial period of seven months, which begins three months before the month you turn 65 and ends three months after the end of that month. For example, if you turn 65 in July, your initial enroll-

ment period starts April 1 and ends October 31. However, the earlier you enroll during this initial period, the better. If you enroll during the three months before you turn 65, your coverage will begin on your 65th birthday. If you enroll during the remaining four months of your initial enrollment period, your coverage may be delayed from one to three months after you sign up, depending on how long it takes to process your application.

3. Delayed Enrollment

If you do not enroll in Part B medical insurance during the seven-month period just before and after you turn 65, but later decide you want the coverage, you can sign up during any general enrollment period. These are held January 1 through March 31 every year. If you sign up any time during one of these general enrollment periods, your coverage will begin on July 1 of the year you enroll.

Your monthly premium will be higher if you wait to enroll during one of the general enrollment periods instead of when you turn 65. For each year you were eligible for Part B coverage but did not enroll, your premium will be 10% higher than the basic premium.

C. Medicare's Payment of Your Medical Bills

Medicare does not handle day-to-day paperwork and payments with patients and doctors or other health care providers. It contracts out this work to what are called Medicare carriers or intermediaries. These are huge private corporations such as

Blue Cross or other large insurance companies, each of which handles claims for an entire state, and sometimes for more than one state.

The Medicare intermediary in your state receives, reviews, and pays claims. It sends notices that tell you and the medical provider of the amount of benefits paid, the amount of your medical bill that has not been paid, and the amount the health care provider is legally permitted to charge. (See Section E, below, for more on these notices.) And it is with the intermediary that you will initially correspond if you want to appeal a decision about Medicare coverage of health care charges. (See Section F, below, for appeal procedures.)

Medicare intermediaries handle billing for inpatient charges covered under Part A differently from outpatient charges covered under Part B. This section explains the differences in the billing process.

Free Late Enrollment If Covered by Current Employment Health Plan

If you are covered by a group health plan based on your own or your spouse's current employment, you can enroll in Part B coverage after your 65th birthday without having to wait for the open enrollment period and without any penalty. This exception refers only to a group health plan based on current employment, not to one based on retirement benefits from employment.

If you have delayed signing up for Medicare Part B because you have been covered by a health plan based on current employment, you can sign up for Part B coverage at any time while you are still covered, or within seven months of the date you or your spouse end that employment, or the date the health coverage ends, whichever comes first.

I. Inpatient and Home Care Bills

Medicare Part A covers inpatient care in a hospital or skilled nursing facility, as well as some home health care. (See Chapter 11, Sections D4 and D5, for a review of Medicare Part A coverage.)

a. Medicare Billed Directly by Facility

When you first check into a hospital or skilled nursing facility, you present your Medicare card to the admissions office and it takes care of the rest. Similarly, when you and your doctor make arrangements for a Medicare-approved home care agency to provide your care, you give the agency your Medicare number and it takes care of all the paperwork. The provider—the hospital, skilled nursing facility, or home health care agency—sends its bills directly to Medicare. The patient should not have to do a thing to get Medicare to pay its part of the bill.

The hospital, nursing facility, or home care agency accepts as payment in full the amount the Medicare intermediary decides is the approved charge for those of your inpatient services that are covered by Medicare (but see Chapter 11 for a reminder of what costs are covered). Unlike doctors' bills—in which you may be personally responsible for the difference between Medicare's approved charges and the actual amount of a bill—a hospital, nursing facility, or home care agency is not permitted to bill you for any covered inpatient charges over the amounts paid by Medicare. The Medicare carrier will also send you a copy of the bills so that you will know how much has been paid and how much you must cover on your own.

b. Patient Billed for Some Charges

The hospital, nursing facility, or home care agency will bill you, and your private Medicare supplement insurance company if you have such insurance, for:

- any unpaid portion of your deductible
- any coinsurance payments—for example, for hospital inpatient stays of more than 60 days, and
- charges not covered at all by Medicare, such as for a private room you requested that was not medically necessary, or for television and telephone charges.

The Medicare carrier will send you a form called a Medicare Summary Notice that will show what hospital services were paid for and the portion of your deductible for which you are responsible. The hospital or other facility will bill you directly for the unpaid portion of your deductible and for those amounts not covered by Medicare or by Medicare supplemental insurance. (See Chapter 13 regarding supplemental insurance.)

2. Outpatient and Doctor Bills

How much of your covered doctor and outpatient medical bills Medicare Part B will pay depends on whether your doctor or other medical provider accepts assignment of the Medicare-approved amount as the full amount of the bill. (See Chapter 11, Section F, for more information on what Part B pays.)

If assignment is accepted, you—assisted by private medigap insurance or Medicaid—are responsible only for your yearly deductible of \$100, plus the 20% of the approved charges Medicare does not pay.

If the doctor or other provider does not accept assignment, then you and your additional insurance are also responsible for all amounts of the bill up to 15% more than the Medicare-approved amount.

Catching Overbilling

Medicare has been doing a better job in recent years of cracking down on billing errors and fraud by health care providers. But you must still check your bill carefully to determine whether the hospital or other facility has billed you for services you did not receive or services that Medicare has paid, or has charged more than once for the same service.

The Medicare intermediary may look closely at the portion of the bill Medicare is supposed to pay, and if you have medigap supplemental insurance, the insurance company will also check the bill. But neither one will carefully examine the amounts for which you are personally responsible.

Check all medical bills to make sure there are no charges for services you did not receive. Then, place the bill from the facility next to the statement from the Medicare carrier and from your medigap insurance company. Compare them to see whether any amount the facility has billed you directly has been paid by Medicare or by your medigap insurer.

If so, you must contact the billing office at the facility, sending a copy of your statement from the Medicare carrier or medigap insurer which shows that the charges have been paid. If the problem is billing for a service you do not believe you received, ask the facility's billing office to send you a copy of the record of your hospital stay where that service was noted.



HMOs and managed care plans do their own paperwork. If you belong to an HMO or other managed care health plan, the billing office there handles all the Medicare-related paperwork. In fact, Medicare pays most HMOs and managed care plans a flat amount for each enrolled patient, rather than a separate payment for each treatment. All you have to do is pay your plan's own monthly premiums and copayments, and deal with its paperwork. You don't have to directly handle any Medicare forms.

a. Assignment Method of Payment

If your doctor or other health care provider accepts assignment of your Medicare claim, you are personally responsible for your yearly medical insurance deductible of \$100, and then only the 20% of the Medicare-approved amount of the bill that Medicare does not pay. By accepting assignment, the doctor or other provider agrees not to charge you a higher amount than what Medicare approves for the treatment or other covered service you have received.

After you and the health care provider are informed by a Medicare Summary Notice form from Medicare how much the Medicare-approved charges are, the provider's office will either bill you directly for the remaining 20% of approved charges or bill your medigap supplemental insurance carrier if you have one.

Example: Franco was examined for a painful knee by his regular doctor, who then decided to refer him to an orthopedist. Franco asked his doctor to refer him to someone who accepted assignment. The orthopedist examined Franco, took X-rays, and prescribed exercises and some medication. Franco's own doctor charged \$100 for Franco's original examination. The orthopedist charged \$150. Both doctors accepted assignment.

Medicare's approved amount for Franco's regular doctor was \$75 and, for the orthopedist,

\$120. Because Franco had already paid his yearly \$100 deductible for Part B, Medicare paid 80% of the approved amount of each doctor's bill: \$60 to Franco's regular doctor (80% of \$75 = \$60) and \$96 to the orthopedist (80% of \$120 = \$96). Medicare sent these amounts directly to the doctors. Franco had to pay only the 20% difference between the approved amounts and the 80% that Medicare paid.

The following chart shows who paid what amount of Franco's bills in this example.

PAYMENT OF DOCTOR BILLS—ASSIGNMENT ACCEPTED

	Doctor normally charges	Amount approved by Medicare	Amount paid by Medicare (80%)	Amount patient paid (20%)
Initial exam	\$100	\$75	\$60	\$15
Orthopedic exam	\$150	\$120	\$96	\$24
Total	\$250	\$195	\$156	\$39

b. Payment When No Assignment

If your doctor or other health care provider does not accept assignment of the Medicare-approved charges as the full amount of the bill, you—or you and your medigap supplemental insurance—will owe the difference between what Medicare pays and the full amount of the doctor's bill, up to 15% more than the Medicare-approved amount.

Example: In the example above, Franco's own doctor normally charged \$100 for an examination and the orthopedist charged \$150. If neither doctor accepted assignment, but stuck to their normal fees, the payment amounts would be as follows.

Medicare's approved amount for Franco's regular doctor was \$75 and, for the orthopedist, \$120. Medicare paid 80% of the approved amount of each doctor's bill: \$60 to Franco's regular doctor (80% of \$75 = \$60) and \$96 to the orthopedist (80% of \$120 = \$96). Medicare sent these amounts directly to the doctors. With no assignment, Franco would have to pay not only the 20% difference between the approved amounts and the 80% of those amounts Medicare paid, but also the remainder of the unpaid doctors' bills, up to 15% above the Medicare-approved amount, for a total of 35% of the Medicare-approved amount.

The 35% of the approved amount of Franco's regular doctor's bill was \$26.25. And 35% above the approved amount of the orthopedist's bill was \$42. These were the amounts Franco would have had to pay.

The following chart summarizes who paid what amount of Franco's bills in this example.

PAYMENT OF DOCTOR BILLS—ASSIGNMENT NOT ACCEPTED

	Doctor charges	Amount approved by Medicare	Amount paid by Medicare (80%)	Amount patient paid (35%)
Initial exam	\$100	\$75	\$60	\$26.25
Orthopedic exam	\$150	\$120	\$96	\$42
Total	\$250	\$195	\$156	\$68.25



Handling Medicare billing paperwork is free.

Even a doctor or other health care provider who does not accept assignment must fill in the Medicare paperwork and send it to Medicare for payment. And you cannot be charged for processing this Medicare paperwork.

D. Paying Your Share of the Bill

Doctors and other health care providers must wait to find out how much the Medicare-approved charges are before asking you to pay your share. Until they know what the Medicare-approved amount is, they cannot know the legal limit—15% over those approved charges—on how much they can require you to pay. Following your treatment or other service, the doctor's or other provider's office will submit their bills for payment to Medicare. You do not have to submit the paperwork yourself.

If you have private medigap supplemental insurance that pays your deductible and the 20% coinsurance amount that Medicare does not pay, the doctor's office will send its paperwork to the insurance company as well as to Medicare. The doctor will receive payment directly from both Medicare and the supplemental insurance, after Medicare has determined the approved amount for the care you received.

Four to six weeks after you receive a Medicare-covered service, the Medicare intermediary will send you a notice that will include information on:

- how much of each bill is Medicare-approved
- how much Medicare will pay the provider
- how much of your deductible has been met, and
- how much must be paid by you or your private medigap insurance.

This form is called a Medicare Summary Notice, or MSN.

E. How to Read a Medicare Summary Notice

The Medicare Summary Notice (MSN) shows how your claims were settled. The MSN is not a bill. It is a tally of procedures and payments for your information. Every time you get an MSN form, you should check several important pieces of information. (See Section 6, below, for examples of MSN forms, along with notes pointing out important information.)

1. Date of the Notice

You have six months from the date printed in the top right corner of the first page to appeal any decision that your Medicare carrier makes. (See Section F, below, for appeal procedures.) The deadline for filing an appeal is listed on the second page of the MSN.

2. Medicare Intermediary

The name, address, and phone number of your Medicare intermediary is listed in a box in the upper right corner of the MSN. Contact the intermediary if you have questions about the notice or disagree with the way a payment was made and want to appeal. For medical services, this will be the Medicare intermediary in your state that handles almost all Part B claims. For durable medical equipment, however, this will be a regional intermediary, which may be located in another state.

3. Type of Claim

In the middle of the first page, in large, bold capital letters, is a line that reads “Part B Medical Insurance.” The box under this heading describes the type of claims included in the notice.

For example, an MSN might be for Outpatient Facility Claims, referring to laboratory, diagnostic, or surgical procedures you received as an outpatient at a hospital or clinic; another notice might be for Assigned Claims, referring to visits to doctors who accepted assignment of the Medicare-approved amount.

4. Services Provided

In the box beneath the heading “Part B Medical Insurance,” you’ll find the name and address of the doctor or provider of services, the dates of the services you received, and a description of the specific services. The Medicare code for each service will be included in parentheses after the description of the service.

Contact the billing office of the health care provider immediately if you believe that the description of the service is incorrect, or if it is correct and you believe it should be a covered service. Ask workers there to check the description of the service and the code number. If there has been a clerical error, it can be changed in informal contact between the doctor’s office or other provider and the Medicare intermediary.

Coverage may have been denied because the medical service you received was wrongly described as something Medicare does not cover—as a routine physical exam, for example, when you really went in for back pain. Or the descrip-

tion may be correct but the Medicare service code may be wrong. Codes can be jumbled by the doctor's office. In that case, the rejected coverage should have been approved.

5. Division of the Bills

The Part B Medical Insurance box contains columns that show the cost of each procedure or service and how those costs will be divided among those paying:

- **Amount Charged.** The first figure is the amount the doctor or other provider would bill a non-Medicare patient. This usually means nothing to you; a doctor may charge you this full fee only if Medicare does not cover the service at all.
- **Medicare Approved.** Next comes the amount Medicare sets as its approved charges for the service provided. This is often considerably less than what the doctor or other provider would charge a non-Medicare patient. If the doctor has accepted assignment, this amount will be the total the doctor may collect from Medicare and you or your supplemental insurance. If the doctor or other provider did not accept assignment, the total may be only as much as 15% more than these Medicare-approved charges. (See Chapter 11, Section F, for more information on doctors' acceptance of Medicare-assigned charges.)
- **Medicare Paid Provider.** The third figure is usually the amount Medicare paid to the provider. In the case of unassigned claims,

however, this may be titled "Medicare Paid You" and will list the amount Medicare paid you directly.

- **You May Be Billed.** The most important figure is the amount you may be billed. This is the amount Medicare approved (plus 15%, if assignment was not accepted) minus the amount Medicare actually paid. If you have medigap supplemental insurance, this is the amount that will be billed to it for payment. If you have no supplemental insurance, this is the amount you will have to pay out of your own pocket.

The amount you may be billed can include:

- the unpaid portion of your \$100 annual deductible
- the 20% coinsurance amount Medicare Part B does not pay for most covered services
- up to 15% over the Medicare-approved amount for doctors who did not accept assignment, and
- any amount for services Medicare does not cover at all.

6. Sample Forms

The next two pages show a sample Medicare Summary Notice. Along the side are our notations indicating key points of information in the notice.

MSN Form Example #1

	Medicare Summary Notice	Page 1 of 2 July 1, 2004	Date of Notice
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BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

BE INFORMED: Beware of telemarketers offering free or discounted medicare items or services.

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare
555 Medicare Blvd., Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Local: (XXX) XXX-XXXX
Toll-free: 1-800-XXX-XXXX
TTY for Hearing Impaired: 1-800-XXX-XXXX

This is a summary of claims processed from 05/10/2004 through 06/10/2004.

PART B MEDICAL INSURANCE – ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84556 Paul Jones, M.D., 123 West Street, Jacksonville, FL 33231-0024 Referred by: Scott Wilson, M.D.						
04/19/04	1 Influenza immunization (90724)	\$5.00	\$3.88	\$3.88	\$0.00	a
04/19/04	1 Admin. flu vac (G0008)	5.00	3.43	3.43	0.00	b
	Claim Total	\$10.00	\$7.31	\$7.31	\$0.00	
Claim Number: 12435-84956-84557 ABC Ambulance, P.O. Box 2149, Jacksonville, FL 33231						
04/25/04	1 Ambulance, base rate (A0020)	\$289.00	\$249.78	\$199.82	\$49.96	a
04/25/04	1 Ambulance, per mile (A0021)	21.00	16.96	13.57	3.39	
	Claim Total	\$310.00	\$266.74	\$213.39	\$53.35	

Doctor accepted assignment

With assignment, doctor is paid only the amount approved

Medicare pays 80% of its approved amount

PART B MEDICAL INSURANCE – UNASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid You	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84558 William Newman, M.D., 362 North Street Jacksonville, FL 33231-0024						
03/10/04	1 Office/Outpatient Visit, ES (99213)	\$47.00	\$33.93	\$27.15	\$39.02	a
						c

Because patient had already met yearly deductible, Medicare pays 80% of its approved amount

THIS IS NOT A BILL – Keep this notice for your records.

MSN Form Example #1, page 2

Your Medicare Number: 111-11-1111A

Page 2 of 2
July 1, 2004

Notes Section:

- a This information is being sent to your private insurer. They will review it to see if additional benefits can be paid. Send any questions regarding your supplemental benefits to them.
- b This service is paid at 100% of the Medicare approved amount.
- c Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than \$39.02. If you have already paid more than this amount, you are entitled to a refund from the provider.

Deductible Information:

You have met the Part B deductible for 2004.

General Information:

You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud and abuse, call the phone number in the Customer Service Information Box.

Appeals Information – Part B

If you disagree with any claims decision on this notice, you can request an appeal by **November 1, 2004**. Follow the instructions below:

- 1) Circle the item(s) you disagree with and explain why you disagree.
- 2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)
- 3) Sign here _____ Phone number _____

Don't Let a Doctor Take More Than the Law Allows

Medicare rules are clear—and every doctor and other health care provider knows them. You can be charged only an extra 15% above what Medicare decides is the approved amount for a specific medical service. And the Medicare Summary Notice form does the arithmetic for you, stating the amount of the maximum charge.

If a doctor or other provider does not accept assignment and bills you more than the allowable amount, send the doctor's office a copy of your Medicare Summary Notice form, underlining the spot where the maximum bill is stated—and keep a copy for yourself. If you already paid the bill, and the amount you paid was more than the allowable Medicare-approved amount plus 15%, you are entitled to a refund.

Again, contact the doctor's or other provider's billing office and request your refund, letting them know the date you paid the bill, the amount you paid, and the Medicare-approved amount. If they will not refund the overpayment, contact the Medicare carrier, which will then contact the doctor or other health care provider directly.

F. Appealing the Denial of a Claim

Unfortunately, not every request for Medicare payment runs a smooth course. Occasionally, a Medicare hospital or nursing facility review committee may decide your inpatient stay need not last as long as you and your doctor think, and will recommend ending Medicare Part A coverage. Or, more commonly, the Medicare carrier will deny Part B coverage for what you believe is a

covered medical service. Or sometimes it will cover only some but not all of a treatment that you believe should be covered.

You may appeal any of these decisions. This section explains the procedures you must follow.

I. Decisions About Inpatient Care

Occasionally disputes arise about whether treatment as an inpatient in a hospital or skilled nursing facility continues to be medically necessary. These disputes often pit the patient and doctor on one side, and the facility's Medicare review committee on the other. The review committee may believe that the patient can be moved from the hospital to home or to a nursing facility sooner than the doctor advises, or moved from the skilled nursing facility to a non-skilled facility or to home care. If this happens to you, there are several steps you can take to convince Medicare to pay for your continued inpatient care.

a. Coverage Decisions

Initial Medicare approval of whether your treatment must be as an inpatient is made by the facility's Utilization Review Committee (URC), a group of doctors and hospital administrators. The committee makes this determination before you are admitted, or within one day of your emergency admission. The URC also periodically reviews your condition and progress in the facility, and can decide—after checking your medical records and consulting with your doctor—that you no longer require inpatient care at that facility.

Such a decision does not mean that you will be kicked out of the facility, but it may mean that the URC will recommend to Medicare that your inpatient stay at the facility no longer be covered by Part A insurance. If you and your doctor believe you should remain in the hospital, there are procedures to follow which may reverse the URC's decision. And even if the decision is not reversed, the process of appealing can give you a bit more time in the facility without being personally responsible for the huge inpatient bills.

Notice of Noncoverage. If the URC decides that your condition no longer requires inpatient care, it will consult with your doctor. If your doctor agrees, the URC will give you a written Notice of Noncoverage stating that your Medicare hospitalization coverage will end on a certain day. If you do not feel that you should be discharged from the hospital at that point, first express your wishes to your doctor. Ask that the doctor request from the URC that a longer period of inpatient care be approved.

If your doctor is unavailable, ask to speak with the hospital ombudsman. Many hospitals have an ombudsman who is an independent volunteer whose job is to help mediate disputes between the patient and the hospital.

If the doctor or ombudsman cannot change or delay the URC's decision, or your doctor will not oppose the decision, but you still feel that

you should not be discharged, you will have to file an appeal to protect your right to have Medicare Part A cover your inpatient care.

If your doctor disagrees with the URC opinion that you should be discharged, the URC will either back off its decision and not contest your Medicare coverage—in which case you will hear nothing about it—or it will ask for an opinion from the state's Peer Review Organization (PRO). The PRO is a group of doctors who are paid by Medicare to review the medical necessity and appropriateness of inpatient care. This is a bit like the foxes guarding the chickens, but the PROs are also medical professionals who respect the opinions of treating physicians. The PRO will review your medical records, the URC's recommendation, and your doctor's position.

If the PRO agrees that your continued stay at the hospital is medically necessary, you will hear nothing more about the matter and Medicare will continue to cover your inpatient care. However, if the PRO decides that your inpatient care is no longer medically necessary, you will receive a Notice of Noncoverage stating that your coverage for hospitalization will end as of a certain day.

Help From the State Health Insurance Assistance Program (SHIP)

Every state has a program to provide free assistance to any person with questions or problems regarding Medicare, medigap supplemental insurance, Medicare managed care, Medicaid, and long-term care. For example, people often have questions about enrollment, paying bills, and filing appeals. The overall program is called the State Health Insurance Assistance Program (SHIP), though in your state the program may go by one of several different names—Health Insurance Counseling and Advocacy Program (HICAP), Senior Health Insurance Benefits Advisors (SHIBA), or something similar. Whatever the name, the program provides free counseling by professional staff plus trained volunteers. The offices are often connected to legal service agencies that can provide free or low-cost legal advice if the matter involves an interpretation of a law or rule, or a legal battle.

The quality of assistance at SHIP offices tends to be very high. The offices are staffed by dedicated people who are not only knowledgeable and trained to give helpful advice but are also willing to fight for your rights. They sit down with you in person, review your story and papers until they understand your situation, and help you handle the paperwork and telephoning sometimes necessary to make your enrollment or appeal work.

To find the SHIP office nearest you, call the toll-free number for your state's central SHIP office, listed in Section G of this chapter.

Your Doctor Can Be Your Best Ally

The most important element in winning an appeal, particularly for coverage of inpatient care, is gaining your doctor's cooperation. The decision on a Medicare appeal often depends on what the doctor notes in your medical records about your condition and the treatment involved—and on how much assistance you can get from the doctor in providing clarification to the people doing your Medicare review.

The problem is that many doctors view their responsibility to the patient as including only the technical treatment of a medical condition: your body and how it works. Many doctors are not particularly concerned with how you pay the bill, as long as you pay it. And if it's someone else's bill—the hospital's, for example—the doctor may not care if it's paid at all.

If you are fortunate, your doctor will give some attention to your Medicare needs, calling the Medicare appeal personnel and writing a letter, if necessary. If so, you'll find the Medicare appeal process fairly simple. But if your doctor won't take the time to listen to your Medicare problem and help you with the appeal, you may have a frustrating time, which cannot help your recovery process. It may also prompt you to consider changing doctors.

b. Immediate Review

If you receive a Notice of Noncoverage, it will contain important information, including when the URC intends to end your Medicare coverage and whether your doctor or the state PRO has agreed with the decision. How you'll obtain immediate review—the first step in appealing the decision—differs slightly depending on whether your doctor agreed with the URC or the decision was made by the PRO over your doctor's objection.

Immediate review of joint URC and doctor decision. If the Notice of Noncoverage states that your doctor agreed with the URC that coverage for your inpatient care should end, you must take some action to get the process moving.

If you are in the hospital, chances are you may have physical difficulty making phone calls and having conversations to get your immediate review started. You may have a friend or relative act on your behalf by making the necessary call requesting review of your case. You may also ask your doctor to initiate the review, even though he or she initially agreed with the URC's recommendation that Medicare inpatient coverage should end on the specified date. And many hospitals have an independent trained volunteer, called an ombudsman, to assist patients in their dealings with the hospital administration. You can ask to speak with the ombudsman, who can then make your request for immediate review.

Once the PRO has been notified that you are requesting immediate review, they will contact you in order to discuss the matter.

Request an immediate review by the PRO by noon of the first work day after you receive the Notice of Noncoverage. Contact may be made by phone or in writing at the number and address of the PRO given on the Notice.

A representative of the PRO will speak with you directly about why you believe you still require inpatient care—and with the doctor who had you admitted to the hospital, or with the physician overseeing your care.



Try again with your doctor. Help from your doctors is the best hope you have of convincing the PRO to approve your continued coverage. Speak with the doctor again and try to change his or her mind. Sometimes a doctor agrees with the URC decision on care without consulting the patient, or based on an expectation of the patient's improvement that has not occurred. Also, there may be more than one doctor treating you. If so, try to enlist the help of your other doctors. Ask them to speak with your admitting physician to convince him or her that you need more inpatient care.

The PRO will review your case and, within a matter of days, inform you directly of its decision—either by phone or in writing. If the PRO agrees with the facility that your coverage should end, coverage will continue only until noon of the day after you receive notice of the PRO's decision. After that, the facility will bill you for all inpatient costs.



Your coverage will continue during the review. If you have requested an immediate review, Medicare will continue to cover your inpatient care until the PRO makes a decision.

Immediate review of a URC decision your doctor opposes. If your doctor believes that you need to remain in the hospital but the URC disagrees, the URC will have taken your case to the PRO before you receive a Notice of Noncoverage. And the Notice will tell you that the PRO has already agreed with the URC.

You must still ask the PRO for immediate review. But unless you and your doctor can present some strong reasons why the decision should be changed, it will likely remain in effect.

The review process should then proceed as follows:

- Contact the PRO at once by phone or in writing to explain why you believe your continued inpatient care is necessary.
- Ask your doctor—or several doctors if more than one is treating you—to immediately call the PRO to give reasons why your inpatient care continues to be medically necessary. If doctors who are treating you have not previously been in contact with the PRO regarding your case, they can help immensely now by backing up what your admitting physician has said about your continuing need for inpatient care.
- Within three working days of your request for review, the PRO will notify you in writing of its decision.

- Medicare Part A coverage will end the third day after you receive the Notice of Noncoverage, even if the PRO has not yet decided. If the PRO takes the full three days to decide on your coverage and then agrees with the Notice of Noncoverage, you will be personally responsible for the full cost of one full day of hospital costs—the day after coverage stops but on which the PRO has not yet decided.

If the PRO upholds the decision that your inpatient coverage should end, that is not the last word on your Medicare coverage. Similarly, if you did not request immediate review, you can still appeal the decision of noncoverage. Several stages of appeal are open to you, as described in Subsections d, e, and f, below.

c. Have Your Bill Submitted to Medicare

Whether or not you asked for immediate review, you must ask that the hospital or other facility billing office submit the bill to the Medicare intermediary for payment. If you can get strong backing from your doctors, the intermediary might reverse the decision of the URC. Without such support, however, the intermediary will probably uphold the decision of the URC. Either way, if you want to pursue an appeal of the decision, you must have the hospital submit the bill to Medicare. Only by getting a Medicare carrier's decision can you move your appeal to the next stage.

Unfortunately, while the intermediary is deciding on your claim, the hospital or nursing facility may bill you for the uncovered part of your inpatient stay. If you pay the bill and later win your appeal, Medicare will reimburse you.

d. Reconsideration of Carrier's Decision

If the Medicare intermediary denies the claim for payment of part of your inpatient bill, you have 60 days from the date you receive the denial notice to submit a request for reconsideration. You'll find the address for sending this request on the notice denying your claim.

This request for reconsideration can be in the form of a simple letter explaining why your stay in the facility continues to be necessary. Once again, however, it is not so much what you say in your letter as whether you have the support of one or more of your doctors. Ask every doctor who supports your position to send a letter to the intermediary stating his or her medical opinion, and also to give you a copy. Attach a copy of each doctor's letter to your request for reconsideration, and always keep an extra copy for yourself.

It is sometimes difficult to get a doctor to write a letter on your behalf, even if the doctor supports your position. Sometimes it is simply a matter of the doctor being too busy, or not concerned enough with your financial problem, to speak with you in person before you must send in your request for reconsideration. Other doctors charge a fee for writing any letter that does not involve consultation about treatment—as opposed to payment of bills—and the fee may be too high for you.

If you have not obtained a letter from a doctor who supports your position, at least list his or her name and phone number in your request to the carrier. Ask that the carrier contact the doctor before completing its reconsideration.

The intermediary will give you a written decision on its reconsideration. If it again denies coverage, you have 60 days to begin the next step in the appeal process.



Put everything in writing and keep copies.

Keep copies of all correspondence and other papers concerning Medicare claims and appeals. Also, keep notes on all conversations you have with your doctor, representatives from the hospital, the PRO, and the intermediary. Write down the date of the conversation, the name of the person with whom you talked, and what information was given or taken.

e. Request an Administrative Hearing

You have 60 days from the date of the intermediary's written notice denying coverage to request a hearing in front of an administrative law judge. You may request the hearing only if the amount you're contesting is \$100 or more.

The form for requesting an administrative hearing (HA-501 U5) is available at your local Social Security office or online at www.ssa.gov. This form, the process for requesting the administrative hearing, and the hearing itself, are exactly the same as for Social Security appeals. (See Chapter 8, Sections A and B, for details.)

As with every other stage of a Medicare appeal, your doctors' cooperation is the single most important element. Your doctor could appear personally at the hearing and testify on your behalf in front of the judge, but most doctors would charge an arm and a leg to do this. Instead, ask your doctor—or several of your doctors, if possible—to write an explanation of why your medical condition required inpatient treatment. You can then present the written explanation to the judge. Be aware that many doctors charge for writing such a letter, and Medicare laws permit them to do so.

f. Appeals Council and Federal Lawsuit

If the decision of the administrative law judge goes against you, you can file an appeal to the Social Security Appeals Council. (See Chapter 8, Section C, for procedures.) And if that appeal goes against you, you can file an action in federal court challenging the Medicare decision. (See Chapter 8, Section D, for more information.)

You can file such a lawsuit only if the amount you are contesting is \$1,000 or more. Because of the time and expense involved, it is likely you would file such a lawsuit only if the amount is quite a bit higher than that anyway. If you are considering such a lawsuit at this stage, consult with an experienced attorney. You may be able to get a referral to such an attorney from a SHIP office. (See Section G, below, for contact information.)

2. Payment of Doctor and Other Medical Bills

During the course of one or more of your Medicare Part B medical insurance claims, you may disagree with the carrier's decision about whether a particular treatment or service is covered by Medicare. If you find that the Medicare carrier has denied coverage for a certain bill, you have a right to appeal. However, the Medicare Part B appeal process is quite limited, and most people have more success informally contacting the carrier than they do with formal appeals.

a. Read the Medicare Summary Notice

The place to start with a question or complaint about your Medicare Part B coverage of a particular treatment or service is the Medicare Summary

Notice (MSN) you receive from the carrier. (See Section E, above, for a discussion of the MSN.) It not only shows whether a health care service is covered but also gives a description of the service, a Medicare code number—called a procedure code—for the service, and an explanation of why a particular service was not covered.

Certain services are covered if they are described one way by your doctor's office in the Medicare forms they submit, but not covered if described differently. These problems are sometimes caused simply by the wrongly placed checkmark—for example, indicating a routine physical exam (not covered) instead of indicating physical examination for a particular patient complaint (covered). Such a mistake could be made by any number of people involved in handling your claim: your doctor, someone in your doctor's office, or someone in the Medicare carrier's vast paperwork machinery.

The MSN may also indicate that you were denied coverage for a particular service because you had the service performed too frequently during a given time. For example, you may have had two mammograms in one year when Medicare normally only covers one per year. However, if the treatment was determined to be medically necessary by your doctor—because, for example, you have a family history of breast cancer, or prior exams have disclosed potential problems—Medicare can and should cover the second mammogram.

In either situation, the next step is to contact your doctor's office to get a letter supporting the medical necessity for the treatment provided.

b. Check With Your Doctor's Office

If you believe that the MSN incorrectly describes the service or treatment you had, call your doctor's office and ask whether the claim form

sent to Medicare had the same information as shown on your MSN. If either the claim form or the MSN had incorrect information, ask that the doctor's office contact the carrier with the correct information.

If coverage was denied because Medicare claims the treatment was not medically necessary or that you received the treatment too often, ask the doctor to write a letter explaining why the treatment was medically necessary. Also, ask that doctor to make a copy of any of your medical records that support this conclusion—and to send the letter and records to you so that you can then deal with the Medicare carrier.

c. Contact the Medicare Carrier

Most mistakes in billing and coverage are corrected informally, by phone and letter. The Medicare carriers know that mistakes are often made, and they would rather correct them quickly and inexpensively than go through a lengthy and more costly appeal process.

The number to call to reach your carrier is printed in the "Customer Service Information" box in the upper right-hand corner of the first page of your MSN. When you reach your Medicare carrier, give your name, your Medicare number, and the date of the MSN, explaining that you want to discuss coverage of a particular item. Then explain why you believe a mistake was made and describe your doctor's response to the problem. If you have a letter or any medical records from the doctor that explain matters, tell the Medicare carrier what you have. The carrier will either contact your doctor's office or ask you to send in a copy of your doctor's letter, or both.

If this informal contact results in a change in decision by the Medicare carrier, it will send you a revised MSN explaining what the new Medicare payments are and how much you owe. If it

does not change the coverage decision based on this informal contact, your next step would be to push on to a more formal written appeal.

d. Write a Request for Review

If you have not been able to resolve the coverage question informally, you have six months from the date of the MSN within which to file a written request for reconsideration of the carrier's decision—also called a request for review.

Make a copy of the MSN, circle the items you want to challenge, sign the back of the copy, and send it to the carrier listed on the front of the form. Although the MSN says you may write your appeal on the form itself, it is better to send along a separate, signed letter with the MSN, stating your reasons for appealing. There is very little space allowed for your statement on the appeal form, usually not enough to explain your reasoning adequately.

The letter should include your full name as it appears on the MSN, your Medicare number, the date of the MSN, the date of the disputed medical service, and a brief explanation of why you believe the treatment or other service should be covered. Include any letter or other records from your doctor that support your position.



Hold on to the documents. Keep copies of all letters and documents you send to or receive from the Medicare carrier and from your doctor. Also, keep notes of every conversation you have with anyone at the Medicare carrier, including the date of conversation, the name of person with whom you spoke, and any action decided upon in the phone call—such as, you will send them a letter, they will contact your doctor, or they will call you back within a week.

Time to Seek Assistance

If you are considering a request for a review of your medical bills, or you have completed the written review and are considering a request for a hearing, it may be time for you to get some assistance from a local State Health Assistance Program (SHIP) office. (See Section G, below, for contact information.) This is particularly true if the amount you are contesting would put a sizable hole in your budget.

If you are considering an appeal to an administrative law judge for hearing, you may want to consider not only help from SHIP but also the assistance of an experienced Medicare lawyer. (See Chapter 8, Section E, for tips on finding legal help.) SHIP can also help refer you to such lawyers.

On the following pages are samples of request-for-review letters to a Medicare carrier. There are no magic words you must include in such a letter, but these examples demonstrate the kind of simple information required. A letter should include several key points, each of which should be described as briefly and clearly as possible. Keep in mind that the letter is meant merely to point out how and where the error was made and where proof of the error can be found, not to serve as proof itself. Only your medical records and opinion of doctors can actually prove anything.

First, you should briefly describe the treatment you received.

Second, you should point out the specific reasons why the intermediary's decision not to cover the treatment was incorrect—for example, you did not have merely a routine physical exam

but an exam to determine the cause of a specific problem, or you did not have a dental exam but an examination of the nerves in your jaw made by an oral surgeon.

Third, refer to the doctor's letter or other medical records that support your claim.

Notice that at the bottom left of each letter is the notation "cc:" and next to it the name of the doctor. This indicates to the Medicare carrier that you have sent a copy of this letter to your doctor—an action you should take so that the letter goes into your medical file. Sending a copy of the letter to the doctor will help prepare the doctor if the Medicare carrier contacts him or her, and it may remind the doctor to do a better job of explaining the medical necessity of your care the next time you have treatment.

When the carrier reconsiders your claim, it will review your file, check the documents on which the original decision was made, and investigate any new information you have presented or the carrier has obtained by contacting your doctor. You do not have an opportunity at this stage to appear in person and explain things.

If a mistake was made because incorrect or incomplete information had originally been provided to the carrier or someone made a simple clerical error, the carrier is likely to reverse its decision and provide you with coverage. You will then receive a written notice of its review determination and a new MSN.

If there is a dispute about whether a certain treatment truly was medically necessary, the carrier may well reverse itself at this stage, but it does so less often than in cases of simple clerical errors or missing documentation from the doctor.

Request for Review Letter: Sample #1

Betty Patient
222 Public Street
Consumer, USA 12345
telephone: 123-123-1234

March 1, 2005

Transprofit Insurance Company
P.O. Box 123
Moneyville, USA 12345
Re: Request for Review and Reconsideration
Medicare Part B
Medicare Number xx-xxx-xxxxA
MSN Notice dated January 2, 2005

To Whom It Concerns:

This letter is a request for review and reconsideration of a decision made by Transprofit denying coverage of medical treatment I received on November 1, 2004. A copy of the MSN notice of January 2, 2005, denying coverage, is enclosed.

I believe that Transprofit denied coverage of the mammogram I received on November 1, 2005, from Dr. Alice Well because I had previously had a mammogram in January, 2005, which Medicare covered, and Medicare does not normally cover more than one mammogram per year. However, this second mammogram was medically necessary because I have a family history of breast cancer and because my previous mammogram in January showed some spots of potentially cancerous tissue.

Apparently the original Medicare claim from my doctor's office did not include this background information. However, I am enclosing a copy of a letter from Dr. Well and a copy of the medical records from my January mammogram to indicate why the second mammogram was medically necessary.

Based on this information, please reconsider the original decision denying Medicare coverage of the November 1 treatment.

Yours truly,

Betty Patient
cc: Dr. Alice Well

Request for Review Letter: Sample #2

Andy Q. Everyone
18B Main Street
Anytown, USA 12345
telephone: 222-222-2222

June 1, 2005

Ourworld Insurance Inc.
P.O. Box 567
Big Money, USA 12345
Re: Request for Review and Reconsideration
Medicare Part B
Medicare Number xx-xxx-xxxxB
MSN Notice dated March 1, 2005

To Whom It Concerns:

This letter is a request for review and reconsideration of a decision made by Ourworld Insurance denying coverage of medical treatment I received on January 10, 2005. A copy of the MSN notice of March 1, 2005, denying coverage, is enclosed.

I believe that Ourworld Insurance denied coverage of the eye exam I received on January 10, 2005, from Dr. Barry Eyesore, because Dr. Eyesore's office mistakenly noted on the Medicare claim form that I underwent a routine eye examination refraction on that date, marking on the form procedure code 92015.

This was a mistake. In fact, I had a specific examination and treatment for blurred vision and eye pain that I had been suffering. Dr. Eyesore's records indicate that this was a medically necessary examination for a medical condition, for which he prescribed medication, rather than a routine eye examination. Enclosed is a copy of my medical record from Dr. Eyesore indicating the nature of the exam on that date.

Based on this additional information, please reconsider the original decision denying Medicare coverage of the January 10, 2005 examination and treatment of my eyes.

Yours truly,

Andy Q. Everyone
cc: Dr. Barry Eyesore

e. Request a Carrier Hearing

If the carrier reviews your file and still refuses to cover your treatment, and the amount of the disputed bill is \$100 or more, you can continue your appeal by requesting a hearing. To reach the \$100 minimum, you can combine different claims as long as each individual claim has gone through the review and reconsideration process.

You have six months from the date of the written notice of determination to request a hearing. The address to which to send your request is printed on the carrier's written notice of determination following reconsideration.

The letter requesting a hearing is similar to the letter requesting review and consideration, except that you should refer to the date of the carrier's written determination following review in addition to the original MSN.

In separate paragraphs, make the following points:

- Describe the treatment you received and the dates on which you received it. This description should be brief, since the carrier will get its full explanation from your medical records.
- State the specific reasons why the intermediary's initial decision to cover the treatment was incorrect.

- Refer, by name and date, to your doctor's letter and to the specific medical records that support your claim.

Attach to your request for a hearing copies of letters from your doctors and of your medical records, if you have them. Also, call your doctors' offices to request that they send copies of your records to the hearing office at the address you have been given on the notice.

A week before the hearing, call the hearing office and ask whether it has received your letter and any documents you included, plus any medical records you asked your doctor to send. If medical records have not yet arrived and you cannot be sure that your doctor will get them to the hearing in time, ask that the hearing be rescheduled to a later date.

If you want to appear personally at the hearing, make that request in your letter. You will be notified where and when the hearing is to take place. If you later change your mind about appearing, or cannot manage to get to the hearing, you can always call the hearing office to ask that the hearing be rescheduled.

Letter Requesting Carrier's Hearing

Rosa Albartez
3456 Broadway
Anytown, USA 45678
telephone: 333-333-3333

June 1, 2005

Your Money Insurance Co.
P.O. Box 1234
Greentown, USA 12345
Re: Request for Hearing, Medicare Part B
Medicare Number xx-xxx-xxxxC
Notice of Determination After Review Dated May 1, 2005

To Whom It Concerns:

This letter is a request for a hearing by the carrier following a determination made on May 1, 2005. That determination upheld a decision made by Your Money denying coverage of a medical service I received on February 1, 2005, and laboratory work performed on February 5, 2005. A copy of the MSN notice of March 15, 2005, denying coverage, is enclosed. Also enclosed is a copy of the written determination after review, dated May 1, 2005.

I believe that Your Money denied coverage of the physical examination I received from Dr. Walter Thorough and of laboratory work ordered by Dr. Thorough because Dr. Thorough failed to give certain information to the carrier. The physical and the laboratory tests were not routine examinations but were a response to severe muscle fasciculation and cramping that I had been suffering over the previous several weeks. Dr. Thorough's records indicate that the examination and laboratory tests were medically necessary to diagnose and treat my condition.

I have enclosed a copy of my medical records from Dr. Thorough, as well as a letter from Dr. Thorough, both of which make clear that the examination and laboratory tests were medically necessary and should be covered by Medicare.

I want to appear personally at the hearing scheduled for this matter.

Yours truly,

Rosa Albartez
cc: Dr. Walter Thorough

f. Hearing Before Carrier Hearing Officer

The carrier's hearing is held before a hearing officer who has expertise in medical matters. The hearing officer is not an employee of the carrier (though the carrier must pay for his or her services). Therefore the officer may be willing to change the carrier's original decision even though the carrier did not do so during its own review.

The hearing is an informal affair in which the hearing officer will ask you to explain why you think the medical services you received should be covered. Your personal explanation probably won't add much to your doctor's letter and your medical records, but it will usually give you an advantage over simply presenting your claim in writing.

If you appear at the hearing, you can answer questions the hearing officer might have, and you can check to see that the officer's file contains your medical records and letter from your doctor. If the file is incomplete, you can give copies to the hearing officer right then and there; make sure to bring extra copies of everything to the hearing.

Also, hearing officers are more likely to be sympathetic to a real person than to a file of papers. Of course, this means that you must be honest and polite with the hearing officer; it won't do you any good to rant and rave, or to appear to demand anything unreasonable.

You will receive a written notice of the hearing officer's decision in the mail—usually in two to six weeks. If the hearing officer reverses the carrier's decision, you will receive a new MSN from the carrier explaining the new payment amounts.

g. Hearing Before Administrative Law Judge

If your claim for coverage is once again denied after the carrier's hearing, you can request a hearing before an administrative law judge if the amount you are contesting is \$500 or more. If the amount in dispute is less than \$500, the hearing before the carrier's hearing officer is the end of the line.

You must request a hearing before an administrative law judge within 60 days of the date you receive written notice of the decision by the carrier's hearing officer. (See Chapter 8, Section B, for a full discussion of the administrative hearing process.)

h. Appeals Council Review

If you do not receive a favorable ruling from the administrative law judge, you may appeal the decision to the Social Security Appeals Council. (See Chapter 8, Section C, for procedures.) In Medicare Part B claims, the written appeal must be filed within 60 days of the date of the administrative law judge's written decision.

i. Federal Court Case

It is highly unlikely that a Medicare Part B decision will involve enough money that it would be economically sensible for you, and a lawyer representing you, to file a lawsuit in federal court to challenge a negative decision by the Appeals Council. However, if your claim is for \$1,000 or more, you do have such a right. You must file the lawsuit within 60 days of the written decision by the Appeals Council. (See Chapter 8, Section D, for further discussion of the federal appeals process.)

G. State Health Insurance Assistance Programs (SHIP)

These are the phone numbers for the central office of each state's nonprofit organization for consumer counseling about Medicare, medigap, managed care, and related matters. The organization operates under the general name State Health Insurance Assistance Program (SHIP), though in some states it has a similar but slightly different name. These central offices can direct you to a local counseling office near you.

Alabama	800-243-5463
Alaska	800-478-6065
Arizona	800-432-4040
Arkansas	800-224-6330
California	800-434-0222
Colorado	800-544-9181
Connecticut	800-994-9422
Delaware	800-336-9500
District of Columbia	202-676-3900
Florida	800-963-5337
Georgia	800-669-8387
Hawaii	808-586-7299
Idaho	800-247-4422
Illinois	800-548-9034
Indiana	800-452-4800
Iowa	800-351-4664
Kansas	800-860-5260
Kentucky	877-293-7447
Louisiana	800-259-5301
Maine	800-750-5353
Maryland	800-243-3425

Massachusetts	800-882-2003
Michigan	800-803-7174
Minnesota	800-333-2433
Mississippi	800-948-3090
Missouri	800-390-3330
Montana	800-332-2272
Nebraska	800-234-7119
Nevada	800-307-4444
New Hampshire	800-852-3388
New Jersey	800-792-8820
New Mexico	800-432-2080
New York	800-333-4114
North Carolina	800-443-9354
North Dakota	800-247-0560
Ohio	800-686-1578
Oklahoma	800-763-2828
Oregon	800-722-4134
Pennsylvania	800-783-7067
Puerto Rico	800-981-4355
Rhode Island	401-462-3000
South Carolina	800-868-9095
South Dakota	800-822-8804
Tennessee	877-801-0044
Texas	800-252-9240
Utah	800-541-7735
Vermont	800-642-5119
Virginia	800-552-3402
Virgin Islands	809-778-6311
Washington	800-397-4422
West Virginia	877-987-4463
Wisconsin	877-333-6202
Wyoming	800-856-4398





Medigap Insurance

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Even for people who have coverage from both Medicare Part A and Part B, a serious illness or injury can cause financial havoc because of the bills Medicare leaves unpaid. Well over half of all Medicare recipients age 65 and older respond to this risk by buying a private supplemental health insurance policy known as medigap or med-sup insurance.

The term medigap comes from the fact that these insurance policies are designed to cover the gaps in Medicare payments. Unfortunately, most medigap coverage is not nearly as complete as its advertising would lead you to believe.

The alternatives, HMOs and other managed care plans, typically provide broader coverage at slightly lower cost than most medigap insurance policies. However, HMOs and managed care restrict the doctors and facilities available to you in ways that most medigap policies do not. And in recent years, Medicare managed care plans have been dropping seniors in large numbers, adding an element of risk to the managed care option.

Before choosing one type of coverage or another, compare benefits and approaches and measure your preferences against the price you would have to pay for each. This chapter gives you guidance about the gaps in Medicare that need to be filled, and the types of medigap insurance policies that exist to partially fill them. Chapter 14 covers the various types of managed care plans available as alternatives to medigap supplements. Before selecting either a medigap policy or a managed care plan, review the advantages and disadvantages discussed in Chapter 14, and use the charts at the end of that chapter to compare the costs of and coverage provided by individual policies and plans.

Insurance From Continuing or Former Employment

Many people who are eligible for Medicare continue to work and have health insurance through their own or their spouse's employer. The law requires employment group health plans to offer the same coverage to people ages 65 and over as they do to younger people.

And many other people keep their job-related health insurance after they retire, as part of their retirement benefits package, although they usually have to pay much more than a current employee.

Employment-based health plans require you to sign up for Medicare when you turn 65, but will cover you in conjunction with Medicare. The health benefits or human resources office at your work or union can explain the details of coordinating coverage.

The fact that you are eligible for a work-related health plan, however, does not mean that you have to continue with it. Work-related health insurance has become more expensive and less comprehensive for employees—particularly retired employees. You may find that Medicare plus a medigap policy, or Medicare through an HMO, provides you with better coverage at a better price than does your work's medical insurance combined with Medicare.

Even if you decide not to participate in the regular health plan offered in your workplace, your employer's insurance company may offer you a different policy with limited coverage for some services Medicare does not cover at all, such as prescription drugs, dental care, or hearing aids. Compare such a policy with the medigap policies and managed care plans discussed in this chapter to see which one offers you the best coverage for your money.

A. Gaps in Medicare

When considering the kinds of supplemental coverage available, keep in mind the specific gaps in Medicare payments that you are trying to fill. Medicare coverage is explained in detail in Chapter 11, but some of the most significant things it does not cover, or covers but only partially pays, are listed below.

I. Gaps in Part A Hospital Insurance

Medicare Part A covers almost all the cost of most hospital stays. Its most common gap is the deductible, which everyone must pay before Medicare pays any part of a hospital bill. A much less frequent but much more frightening gap is the daily coinsurance amount for hospital stays of more than 60 days. All of the gaps are listed below.

a. Hospital Bills

Medicare Part A hospital insurance does not pay the following costs during a hospital stay:

- a deductible for each benefit period—\$912 in 2005
- a daily coinsurance amount (\$228 in 2005) for each day you are hospitalized more than 60 days and up to 90 days for any one benefit period
- a daily coinsurance amount (\$456 in 2005) for each day you are hospitalized more than 90 days and up to 150 days for any one benefit period
- anything past a hospitalization of 150 days

- first three pints of blood, unless replaced, and
- anything during foreign travel.

b. Skilled Nursing Facility Bills

Medicare Part A does not pay the following costs during a stay in a skilled nursing facility:

- a coinsurance amount of \$114 per day for each day you are in the facility more than 20 days and up to 100 days for any one benefit period, and
- anything for a stay of more than 100 days.

c. Home Health Care

Medicare Part A does not pay the following costs for home health care:

- 20% of the approved cost of durable medical equipment or approved nonskilled care, and
- anything for nonmedical personal care services.

2. Gaps in Part B Medical Insurance

Medicare Part B leaves some very large gaps in the amounts it pays doctors, depending on whether the doctors accept assignment. Everyone faces the 20% of the Medicare-approved amount that Medicare does not pay. And if your doctor does not accept assignment, you are also responsible for up to 15% more than the amount Medicare approves. The other largest uncovered expense, particularly for older people, is for prescription medication.

Medicare Part B does not pay the following costs for doctors, clinics, laboratories, therapies, medical supplies, or equipment:

- \$110 yearly deductible
- 20% of the Medicare-approved amount
- 15% above the Medicare-approved amount if the provider does not accept assignment
- 20% of the total charges for outpatient hospital services
- preventive or routine examinations and testing
- prescription medication
- dental care, or
- routine eye and hearing exams, or glasses or hearing aids.

B. Standard Medigap Benefit Plans

In the first 20 years of Medicare's existence, insurance companies produced a dizzying array of insurance policies intended to supplement Medicare coverage. At best, they were confusing to consumers. At worst, they offered unnecessary or duplicate coverage and contained numerous escape clauses by which the insurance companies avoided payment. Finally the federal government stepped in to regulate medigap policies.

Now, insurance companies can offer only ten standardized benefit plans, referred to by all insurance companies as Medicare supplement benefit plans A through J. (Massachusetts, Minnesota, and Wisconsin have their own, slightly different, standardized policies; see Section 2, below, for details.)

Beware of Private Coverage Agreements

A few doctors who regularly treat Medicare patients try to pad the amounts Medicare and medigap insurers will pay them by inducing patients into private side agreements. In these side deals—sometimes called retainer agreements or prepayment contracts—the doctor agrees to accept assignment of Medicare amounts and sometimes to waive the yearly Medicare deductible and copayment amounts. In exchange, the patient agrees to undergo and pay for, sometimes in advance, certain services Medicare does not cover at all, such as routine physical exams and testing. Other agreements require that the patient pay a set amount out of pocket for a service that Medicare would normally cover.

These agreements can result in Medicare patients paying hundreds, even thousands, of dollars for services that should be covered by Medicare, or which they may not need. Some of these doctors claim that these agreements preserve the freedom of the patient to have the doctor they want. In truth, they blackmail the patient into either paying or finding another doctor. They bilk unnecessary expenditures from the patient and set up an unhealthy forced relationship between doctor and patient. Under Medicare rules, virtually all of these contracts are illegal.

If you are offered any such contract, turn it down. And report the matter to the United States Department of Health and Human Services at 800-638-6833. Or contact your state's department of insurance, which you can find under the state listings in the government section of your telephone directory.



Delay may limit your choices. Insurance companies would be happiest if they could sell coverage only to healthy people. For most types of health insurance, you'll find it hard to buy a policy if you're already ill.

The federal government has, however, established some protections for people buying medigap policies. But taking advantage of these protections depends on when and under what circumstances you apply. You'll receive the most coverage options if you apply within the first six months after you begin your Medicare Part B coverage. In a few other circumstances, you may also have options to purchase some, though not all, medigap policies without fear of being turned down because of your preexisting condition. If you wait too long to apply for a policy, however, the insurance companies are allowed to review your medical records and reject you if they consider you a bad profit risk. To understand the rules regarding your right to purchase a medigap policy, see Section C, below.

Not every company offers every plan. And only the benefits included in the plans are standardized. Other important aspects—premium increases and preexisting illness exclusions—vary from policy to policy and require careful comparison shopping.

When you consider medigap policies, your task is to see how many of the gaps in Medicare payments you can fill within the constraints of your budget. The broader the coverage in a medigap policy, the higher the cost.

And although the benefits are standardized, the cost of a standard policy varies widely from company to company. So you must determine not only which benefit plan best suits your

needs, but which company offers which plan at the best price. Then examine the other elements of each policy, such as premium increases and preexisting illness exclusions, before making your choice.

Medigap Does Not Cover Long-Term Care

Many older people fear the possibility of living out the final years of life in a nursing home. The prospect of nursing home life itself provokes distress for many, as does the financial ruin that can be brought about by the cost of long-term care. Unfortunately, neither Medicare nor medigap supplemental insurance nor managed care health plans protect against this potentially enormous cost. Medicare covers only a limited period of skilled nursing facility care and covers nothing of long-term custodial, or nonmedical, care in a nursing home. Medigap policies and HMOs similarly fail to cover long-term nursing home care.

Long-term care at home is increasingly an option for people who in years past would have been forced to enter a nursing home. More services are available at home, and more agencies and providers offer home care. However, neither Medicare nor medigap policies cover long-term home health care.

There is a type of private insurance that can cover some of the cost of long-term nursing home or at-home care. Referred to as long-term care insurance, it is available in a variety of benefit packages but comes with numerous restrictions and exclusions. The cost of these policies varies greatly, depending on the extent of coverage and the age of the person covered.

For a complete discussion of these policies and the kinds of care they cover, see [Long-Term Care: Home Care, How to Plan & Pay for It](#), by Joseph Matthews (Nolo). See Nolo's website at www.nolo.com for ordering information.

I. Basic Benefits Included in All Medigap Plans

The benefits included in the ten standard medigap plans and a chart comparing their coverage follow.

All ten standard medigap policies begin by offering the same basic benefits, including coverage of:

- hospital coinsurance amounts under Medicare Part A
- 365 days of hospital coverage after Medicare coverage ends
- three pints of blood transfusions a year, and
- Medicare Part B coinsurance amount (20% of Medicare-approved amounts).

Notice that these basic benefits really are meant to close gaps in Medicare coverage, not to provide separate medical insurance. If a hospitalization or medical treatment is not covered at all by Medicare, a medigap policy will not cover any of it, either. The exception to this is those policies that cover foreign travel and some preventive care.

Medigap: It Pays to Shop Around

The federal government decides what benefits must be included in standard medigap policies. But it does not control prices, which vary widely. Prices vary for different ages. They also change from state to state, reflecting regional health care costs and level of competition for customers.

But the price for the same policy may vary tremendously even within the same state. Even the most basic Plan A policy can vary in cost by hundreds or even thousands of dollars per year in some states. And the more extensive the plan, the greater the cost disparity among policies from different insurance companies.

Most of the time there is no basis for the price disparities other than “name” recognition. Don’t fall for the first policy that comes along. Even when you’ve decided what standard policy you want, comparison shop for the best price from several different insurance companies.

a. Inpatient Hospital Costs

For every benefit period, every plan pays all your Medicare Part A coinsurance amounts through your first 90 days as an inpatient, plus your coinsurance amount for any reserve days. After your reserve days are used up, every plan pays for the entire Medicare-approved amount of hospital charges for an additional 365 days. The basic plan also pays for the first three pints of blood you receive. However, it does not pay your Part A deductible.

b. Medical Expenses

Every plan pays the 20% coinsurance amount Medicare Part B does not pay. It also pays the 20% of Medicare-approved home health care amounts not paid by Medicare. The basic medigap benefits do not, however, include your Part B deductible or the 15% above the Medicare-approved amount that a doctor is allowed to charge if he or she does not accept assignment. (See Chapter 11, Section F, for more on Part B coverage issues.)



Make sure there are limits on premium raises. It is always important to check the terms under which an insurance company may raise the amount of your premium. But it is particularly important when the initial premium already stretches your budget. Pay particular heed to the rules regarding hikes in medigap insurance premiums. (See Section C, below.)

2. Standard Medigap Plans

There are currently ten standard Medigap policies available—summarized in the chart below and discussed more fully in the subsections that follow.



Some medigap plans will change in 2006.

Assuming the Medicare Modernization Act of 2003 goes into effect as written at the beginning of 2006, standard medigap policies Plans H, I, and J will be replaced by the new Medicare prescription drug coverage. If you have one of these policies, your insurance company will notify you of the change in coverage and premiums.

Plans F and J also have a high-deductible option. You could choose to pay the first \$1,600 in out-of-pocket costs—for any covered service—per year before the insurance company pays a cent. The reason you might choose this is that these versions of Plan F and J are less expensive than the regular Plans F and J offered by the same companies.

The Ten Standard Medigap Insurance Policies

All plans include these basic benefits:

- Hospitalization: Medicare Part A coinsurance plus 365 days of coverage after Medicare ends
- Medical costs for outpatients: Medicare Part B coinsurance (20% of Medicare-approved costs)
- Blood transfusions: the first three pints of blood each year

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Medicare Part A Deductible		X	X	X	X	X	X	X	X	X
Medicare Part B Deductible			X			X				X
Skilled Nursing Coinsurance			X	X	X	X	X	X	X	X
Foreign Travel			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Preventive Care					X					X
Doctors' Excess Charges						(100%) X	(80%) X		(100%) X	(100%) X
Prescription Medicine								(\$1,250) X	(\$1,250) X	(\$3,000) X

Special Rules for Massachusetts, Minnesota, and Wisconsin

If you live in Massachusetts, Minnesota, or Wisconsin, the standard medigap policies are somewhat different from the ten standard policies offered elsewhere. Each of these three states has a basic plan plus options. You pay extra for any of the options you choose. The basic benefits in Massachusetts and Wisconsin include some things that the ten standard medigap policies do not. For information on the details of medigap policies in any of these states, call your state's Department of Insurance. You'll find their phone numbers at the end of this chapter.

a. Medigap Plan A

Plan A medigap policies include only the basic benefits discussed earlier. (See Section B1, above.) Because of their limited benefits, Plan A policies are the least expensive.

Plan A policies are most useful if the doctors who regularly treat you accept assignment of Medicare-approved amounts, and you can afford to pay for the uncovered costs of doctors who do not accept assignment but by whom you might have to be treated. (See Chapter 11, Section F, regarding assignment practices.) Also, you must be able to afford the Part A hospital insurance deductible, bearing in mind that because there is a separate deductible for each separate hospital stay, you may have to pay it more than once in a year. (See Chapter 11, Section D, regarding Part A coverage.)

If these potential expenses plus the cost of a Plan A policy would put a severe strain on your

finances, consider the alternative of an HMO, which may provide broader coverage for less money. (See Chapter 14 for a full discussion of the HMO option.)

b. Medigap Plan B

In addition to the basic benefits, a Plan B policy also pays your Medicare Part A deductible.

If your doctors all accept assignment but your budget would be severely strained by paying more than one hospital deductible in a year, Plan B may be marginally better for you than Plan A. However, if you have to pay more than a few dollars a month more for Plan B than for Plan A, it may be a bad bargain.

Measure the yearly cost of a Plan B against the cost of a Plan A policy. If you are reasonably healthy—meaning you do not expect frequent hospitalizations—and the difference in premiums is more than 25% of the Part A Medicare deductible (\$912 in 2005), it is probably not worth the extra premium, and you should stick to a Plan A policy.

c. Medigap Plan C

Plan C adds three benefits beyond the basic and other ones offered in Plan B. First, it pays your yearly Medicare Part B deductible of \$110. But since this policy will probably cost you more than \$110 per year over Plan A or B, that isn't a good reason to purchase it.

Second, Plan C policies cover the Medicare coinsurance amount for skilled nursing care. Remember that under Medicare skilled nursing coverage, you are personally responsible for a coinsurance amount (\$114 per day in 2005) for

stays of 21 to 90 days in a skilled nursing facility. This can add up to a considerable amount of money, but it applies only if you are covered by Medicare for short-term skilled nursing care in a nursing facility. (See Chapter 11, Section C6, regarding Medicare skilled nursing coverage.) If you have a medical condition that puts you in and out of the hospital, this can be a valuable addition to your policy. But the odds are low that most people will be in a skilled nursing facility for more than 20 days more than once or twice in a lifetime.

Finally, Plan C offers some coverage for medical care while traveling outside the United States. For people who travel abroad frequently, this can be a valuable benefit. After you pay a \$250 deductible, Plan C pays for 80% of emergency medical costs you incur abroad. For purposes of these policies, emergency means any unplanned medical costs; it is not restricted to “emergency room” treatment (as it’s called in the U.S.).

However, there are some restrictions on the coverage. Your emergency medical care must begin within the first 60 days of each trip abroad; if you take long trips, this policy will not protect you after the first two months. And there is a \$50,000 lifetime maximum on these foreign travel medical benefits. If you spend a good portion of each year abroad, you may need a separate—that is, nonmedigap—health insurance policy to cover you fully for treatment received outside the United States.

Remember that your overseas medical care must be emergency care; if you regularly spend time abroad and simply want to be able to see a doctor for ongoing medical problems, this policy will not cover such visits.

The cost for Plan C policies is considerably higher than for Plan A or B but runs about the same as for Plans D and E.

d. Medigap Plan D

Plan D is the same as Plan C, except it does not pay the \$110 yearly Medicare medical insurance deductible. It does, however, pay for a certain amount of at-home recovery following an injury, surgery, or illness.

There are significant restrictions on this coverage. First, it pays only for unskilled personal care—and pays for that only when it has been ordered by your doctor while you are also receiving skilled home health care covered by Medicare. (See Chapter 11, Section C7, regarding Medicare’s home-care coverage.) The Plan D policy pays up to \$40 per visit, up to seven visits per week, but for no more than the number of Medicare-covered home health visits you receive. And there is a yearly maximum of \$1,600.

With all these restrictions, plus the relatively low odds that you will use Medicare-covered skilled at-home care, this coverage is of limited value. A Plan D policy is preferable to a Plan C only if it is available for about the same money and other terms, such as preexisting illness exclusions.

e. Medigap Plan E

Plan E adds minimal coverage of some preventive care but eliminates Plan D’s coverage of at-home recovery. Plan E pays for only \$120 per year of such preventive health care and screening, so it’s not much of a benefit.

If you are deciding between the \$1,600 per year of at-home coverage included in Plan C and the \$120 per year covered by Plan E, offered at virtually the same price, Plan C is a better bet.

f. Medigap Plan F

Plan F offers the most significant added benefit beyond Plans B, C, D, and E: payment of 100% of what a doctor actually charges you above the Medicare-approved amount. (Remember, doctors who do not accept assignment are permitted to charge a patient up to 15% more than the Medicare-approved amount for any covered service, as discussed in Chapter 11, Section F.) If you receive extensive medical care from doctors who do not accept assignment, that extra 15% mounts up quickly.

Because the extra 15% of medical bills can amount to a lot of money, insurance companies charge higher premiums for Plan F than for the plans discussed previously. If you are in generally good health and the few doctors you see all accept assignment, this higher premium may not be worth the extra coverage. If, on the other hand, you require frequent or extensive medical care and you receive it from doctors who do not all accept assignment, Plan F may be worth the higher premiums.

g. Medigap Plan G

Plan G is similar to Plan F, with three significant differences. Plan G does not cover the \$100-per-year Medicare medical insurance deductible Plan F covers, but it does cover at-home recovery as in Plan D. Another difference between

Plan G and F is that Plan G covers only 80% of the 15% excess doctor's charges, while Plan F covers 100% of those charges.

If you are likely to require frequent or extensive treatment by different doctors and you cannot be sure whether they will accept assignment, the extra coverage of Plan F may be worth its higher cost.

On the other hand, if your medical bills are not very high, even though you see a doctor who does not accept assignment, the lower premiums for reduced coverage under Plan G may be a better bargain for you.

h. Medigap Plan H

Plan H, along with Plans I and J, provides coverage for something many older people spend a lot of money on but Medicare does not cover: prescription medication. After you pay a yearly deductible of \$250, Plan H pays up to 50% of the cost of your prescription medication, to a maximum yearly amount of \$1,250. To get the full \$1,250 in benefits, the total cost of your prescription drugs for the year would have to reach \$2,750.

However, Plan H does not cover any of the 15% excess charges a doctor may bill you above what Medicare approves.

This plan is a good one if your doctors accept assignment and you regularly take expensive prescription medication.

i. Medigap Plan I

Plan I is the second-most expensive policy because it includes two of the most significant benefits: coverage of charges by doctors who do not accept assignment and prescription medication (on the same terms as Plan H). It also includes at-home recovery. This policy is a very good one if you can afford the premiums.

However, even if you can afford it, an insurance company that has the policy might not offer it to you. If you have a history of high medical bills or medication costs, an insurance company might not be willing to sell you a Plan I policy.

There is one way around this resistance: If you sign up for the policy during your open enrollment period in the six months immediately following your first enrollment in Medicare Part B, an insurance company that offers Plan I in your state must sell it to you. (See Section C, below, regarding open enrollment procedures.)

j. Medigap Plan J

Plan J is the luxury model of medigap policies. It is also the most costly. And because its coverage is the most extensive, insurance companies tend not to sell it to people who have had extensive recent medical treatment or prescription drug costs, unless they sign up in the mandatory open enrollment period in the six months immediately following first enrollment in Medicare Part B.

In addition to what Plan I covers, Plan J pays the yearly Medicare medical insurance deductible (\$100) and provides a limited amount (\$120) of preventive care. Most significantly, it

more than doubles the total amount of benefits Plan I pays for prescription medication—up to \$3,000 per year. It still pays only 50% of the cost of medication, and you remain responsible for a \$250 deductible for prescription medication. So you can reach the full \$3,000 in coverage only if your total bill for prescription drugs is \$6,250.

Medicare SELECT Medigap Policies

In addition to regular fee-for-service medigap policies, there is a category of supplemental insurance that is partly fee-for-service and partly managed care. It is called Medicare SELECT. A SELECT policy must provide the same benefits as any of the standard A through J medigap policies, but it has a two-tiered payment system.

If you use hospitals—and under some policies, doctors—who are members of the policy's network, the policy pays full benefits. If you use a provider outside the network, the policy pays reduced benefits. In this way, a Medicare SELECT medigap policy works like a preferred provider organization or an HMO with a point-of-service option, except that those managed care plans usually cover more services than most medigap policies. Because of these restrictions, Medicare SELECT policies are somewhat less expensive than regular medigap policies.

C. Terms and Conditions of Medigap Policies

In addition to comparing the services covered, the amount of benefits, and the monthly cost of different medigap insurance policies, there are several other things to consider before making a final decision.

Look first at how high the company says it may raise its premiums in the years to come—and therefore whether you will still be able to afford the policy when you may need it most. Also important are policy terms that determine whether you are covered for a particular illness during a certain time period after you purchase the policy.

I. Premium Increases

It is one thing to find insurance coverage you can afford today. It may be quite another to find a policy that you can continue to pay for in the future when your income and assets have decreased and the policy premium has increased. In choosing a medigap policy, consider what the contract says about how much the policy premiums will rise over time. If the current premium will already be a significant strain on your financial resources, consider a less expensive policy, because any policy is sure to get more expensive in the future.

There are several ways insurance companies set up premium increases in medigap policies. Choosing the best premium increase terms—what the insurance companies call “rating” methods—is something for you to consider along with other terms of the policy.

a. Level Premiums

The best method for the consumer is one called “level premiums.” This means that premiums do not go up on your policy as you reach a certain age, but only when the insurance company raises premiums on all medigap policies of the type you have. Of course, the premiums will go up regularly, but the amount they go up will be at least partially controlled by market forces and by your state’s insurance commission.

b. Attained Age

“Attained age” policies base your premium entirely upon your age. The company charges the same premium to everyone of the same age who has the same policy. As you get older, the premiums rise in lockstep, by a set amount. Some policies mandate that your premiums go up yearly, others hike the premiums when you reach a certain age plateau, such as 70, 75, or 80. Attained age policies tend to be cheaper at age 65 than comparable policies. However, once you reach 70 or 75, attained age policies tend to become, and stay, more expensive than other types.

When considering a policy with attained age premium rises, ask to see not only how much it would cost you at your present age, but also the current premium costs at each of the next age levels. That will give you a sense of how high the rates jump for that policy. Figure that your premiums will rise by at least the same percentages, and calculate how much your policy is likely to cost at your next two age levels. Only then will you have a realistic picture of how much this policy will cost.

Medigap Information on the Internet



Medicare's official website at www.medicare.gov offers a link called "Medicare Personal Plan Finder." By entering your state name and zip code, you'll get information on all your Medicare and medigap plan options, including the names and phone numbers of insurance companies selling authorized medigap policies in your area.

This site is a good and easy place to start your research. But the information on the site is often a bit stale. For more complete and up-to-date information on which insurance companies offer medigap policies in your state, call your state's department of insurance directly. For details about any one policy, you'll need to speak to an insurance company representative or work through an agent.

c. Issue Age

The initial premium for an "issue age" policy is determined by your age when you first purchase it. From then on, as long as you keep the same policy, you pay the same premium as someone else who buys the policy at the same age at which you bought it.

For example, if you buy an issue age medigap policy at age 65, in five years you will pay the same as a person who first buys the policy at that time at age 65. Your premium will steadily rise, but the increases may be controlled by the insurance company's need to keep the premium competitive to continue signing up new policyholders.

d. No Age Rating

A few insurance companies sell policies that charge the same amount regardless of age. They base their premiums entirely on the cost of medical care in the geographic area in which you live. (For this reason, these are sometimes referred to as "community-rated policies.") These policies tend to be a bit more expensive than others for people ages 65 to 75 and a bit less expensive for people age 75 and older.

2. Eligibility and Enrollment

Your ability to purchase the medigap policy of your choice depends on when and under what circumstances you apply for it. We discuss applying during open enrollment periods in Subsection a, below; applying during limited guaranteed enrollment periods in Subsection b; and applying outside these enrollment periods, on your own, in Subsection c, below.

a. Applying During Open Enrollment

You are guaranteed the right to buy any medigap policy sold in your state, without any medical screening or limits on coverage, if you:

- are within your first six months of Medicare Part B (see Subsection i, below), or
- leave a Medicare managed care plan within a year of age 65 (see Subsection ii, below).

i. Your First Six Months With Medicare Part B

During the six months after you first enroll in Medicare Part B (see Chapter 12, Section B, for enrollment procedures), you may buy any medigap insurance policy sold in the state where you live. During this initial enrollment period, federal law prohibits an insurance company from requiring medical underwriting—that is, prior screening of your health condition—before issuing a policy. Nor may the insurance company delay coverage because of preexisting health conditions. Companies are also prohibited from charging higher premiums based solely on your age or area of residence.

Most people enroll in Medicare Part B as soon as they turn 65. Your six-month open enrollment period for medigap begins on the first of the month during which you reach age 65 and are enrolled in Part B.

If you did not enroll for Medicare Part B on your 65th birthday but enroll during a yearly Medicare general enrollment period (January–March), your six-month open enrollment period for any medigap policy begins on July 1 of the same year. If you did not enroll in Medicare Part B on your 65th birthday because you were still covered by an employer-sponsored health plan, you have a six-month open enrollment period for any medigap policy beginning whenever you enroll in Medicare Part B.

ii. You Leave a Medicare Managed Care Plan Within a Year of Age 65

If you joined a Medicare managed care plan (see Chapter 14) at age 65 when you first became eligible for Medicare, but you leave the plan within a year, you have a guaranteed right to buy any medigap plan sold in your state. This is true whether your managed care plan dropped

you—perhaps because it stopped doing business in your county of residence, or because you moved out of its business area—or because you left the plan voluntarily.

However, to protect this guaranteed right, you must apply for a medigap policy within 63 days of the date your managed care plan coverage ends. If you are still in the six-month period immediately following your enrollment in Medicare Part B, you have whatever is left of that six-month period within which to apply for a medigap policy, or 63 days from the end of your managed care coverage, whichever is greater.

Medigap Coverage If You Move

What happens if you buy a medigap policy while living in one place, then move elsewhere? Because all medigap policies are “guaranteed renewable,” your insurance company can’t cancel your policy. This is true even if you move to an area where the company doesn’t normally sell similar policies. However, the insurance company has a right to increase your premium if you’ve moved to an area where the costs of medical care are higher. The rates must be approved by the department of insurance in the state to which you have moved.

b. Applying With Limited Guaranteed Enrollment

You have the guaranteed right to buy a medigap policy if, under certain circumstances, you:

- lose your Medicare coverage (see Subsection i, below), or

- drop medigap, join a Medicare managed care plan, then leave the managed care plan (see Subsection ii, below).

You can use this right for any of several standard medigap plans, though not for all plans. For those plans to which you have no guaranteed right, however, you may still purchase a policy if the issuing insurance company approves your application.

i. You Lose Coverage by a Medicare Managed Care Plan or Employer-Sponsored Medicare-Connected Policy

With alarming frequency, insurance companies all over the United States are dropping their Medicare managed care plans in counties in which the companies are unhappy with their profit margin. (See Chapter 14 for details.)

If you have been dropped from a Medicare managed care plan because the plan is leaving Medicare altogether, or is leaving the county in which you live, you have a guaranteed right to purchase any standard medigap plan A, B, C, or F policy sold in your state. (In Massachusetts, Minnesota, and Wisconsin, you have a right to purchase a medigap policy with provisions similar to these four standard medigap plans.)

You have the same guarantee if you are losing your managed care coverage because you are moving out of the plan's service area. These rules also apply if you lose employer-sponsored insurance which had operated like a medigap policy, meaning that it paid for some costs your Medicare coverage did not.

If you had a medigap plan D, E, G, H, I, or J before dropping it to join a managed care plan that has now dropped you, you also have a guaranteed right to again purchase that same

plan from the same insurance company, if the company still sells the plan in your state.

To take advantage of any of these guaranteed rights, you must apply for a medigap plan within 63 days from the end of your managed care or employer-sponsored coverage.

Some States Offer Extra Protection

Some states' laws offer even more protection around your right to purchase a medigap policy than the federal guarantee described in this chapter. These state laws typically give you more medigap plans from which to choose. To find out what extra protection your state might offer, call your state's department of insurance (see contact information at the end of this chapter) or your local SHIP office (see Chapter 12, Section G, for contact information).

ii. You Dropped a Medigap Policy to Join a Medicare Managed Care Plan or a Medicare SELECT Policy, Then Left the New Plan Within a Year

If you once had a medigap policy but dropped it to join a Medicare managed care plan or to purchase a Medicare SELECT policy (see "Medicare SELECT Medigap Policies," in Section B2, above), you may have a guaranteed right to drop the Medicare plan and repurchase a medigap plan. However, you must meet two conditions:

- The managed care plan or Medicare SELECT policy you drop must be the only one in which you have been enrolled.
- You must leave the managed care plan or drop the Medicare SELECT policy within a year of when you joined.

If you meet these two conditions, you may either buy your original medigap policy from the same company (if it is still sold in your state), or buy any medigap plan A, B, C, or F sold in your state. There is a time limit on applying for the new medigap policy, however. Your guaranteed right to purchase lasts only 63 days from the end of your previous coverage.

c. Applying Without Guaranteed Enrollment

If you want to buy a medigap policy but have none of the guaranteed rights described in Subsections a and b, above, an insurance company can freely choose whether or not to sell you a policy. Even if the company does offer you coverage, it may attach whatever terms, conditions, and premiums it chooses, as long as the coverage matches one of the standard plans.

In such circumstances, the insurance company is likely to demand that you undergo medical underwriting (screening)—particularly before they'll sell you one of their more desirable policies. The screening will involve a detailed examination of your medical history.

If your history shows a likelihood of extensive or expensive medical treatment in the foreseeable future, the company might refuse to sell you the policy. Or, they might offer to sell it to you at a high premium, perhaps also with limitations on when coverage begins.

If you are interested in purchasing any medigap plan H, I, or J, an insurance company almost certainly will require such medical underwriting. For plans A through G, however, some insurance companies will not bother with this screening process.

3. Preexisting Illness Exclusion

Most policies contain a provision excluding coverage, for a set time immediately after you purchase a policy, of any illness or medical conditions for which you received treatment within a given period before your coverage began. Six months is a typical exclusion period. Many policies provide no coverage for six months after you buy the policy for illnesses you were treated for within six months before the policy starts. Usually, the shorter the exclusion period, the higher the premium.

If you have a serious medical condition that may require costly medical treatment at any time, and you have been treated for that condition within the recent past, consider a policy with a short exclusion period or none at all.

D. Finding the Best Medicare Supplement

Shopping for a medigap policy can be difficult, not only because of the differences in policy terms among the ten standard policies, but because of the wide spectrum of prices among insurance companies. At the end of Chapter 14 is a chart to help you do a side-by-side comparison among different medigap and managed care plans.

Fortunately, your first step, namely finding out what medigap insurance policies are available in your state, is fairly simple. Your state department of insurance can give you a complete list of available policies (see the contact information at the end of this chapter). Be warned, however, that their lists are often a bit stale, so you'll need to follow up with the insur-

ance companies or insurance agents for the latest facts and figures. Many people also use insurance agents to find policies, although you should first read the cautions in Section 1, below. In addition, some seniors' organizations offer discounts on certain medigap policies (see Section 2, below).

I. Using an Insurance Agent

If you use an insurance agent to present you with a choice of medigap policies, make sure the agent is experienced with the provisions of several different policies. The benefits may have been standardized into ten policy plans, but other terms of the policy are also important, and price varies widely. Insurance agents tend to work with policies from certain companies and may not know of less expensive or less restrictive policies from other companies. So you may want to consult more than one agent.

Even if you arrange to get your insurance through an agent, keep your own ears and eyes open for policies that might fit your needs. Friends, relatives, and organizations to which you belong may all be resources to find out about available plans. And senior organizations can be a good source of information. (See Section D2, below, for further discussion of senior organizations.) A good insurance agent should be willing to find out the details of a policy you have located yourself. If the agent cannot or will not check on such a policy, it is probably time to find a new agent. Likewise, if an insurance agent is unwilling to sit down with you and compare the coverage and costs of different policies, then you ought to comparison shop for a new insurance agent.

Finally, remember that insurance agents normally do not sell HMO memberships, although some do handle enrollment in managed care plans. And if they do not handle HMO membership or enrollment in a managed care plan, they cannot make money signing you up for one. Therefore, be cautious about an insurance agent who tries to convince you that a medigap policy is better for you than an HMO or managed care plan. That is a decision you have to make yourself after comparing the cost, benefits, and other factors of each plan. (See Chapter 14 regarding HMO and managed care plans.)

2. Senior Associations

A number of organizations of seniors or retired people advertise medigap policies. These organizations do not actually act as insurers. Instead, they negotiate deals with insurance companies to offer medigap policies to their members, sometimes at reduced rates.

But some senior organizations act almost as fronts for insurance companies. These organizations may appear to exist for the benefit of older people, offering a number of programs or services for seniors. But many of these alleged benefits are nearly worthless. In truth, these organizations exist to sell themselves through membership dues and products (including overpriced insurance) behind a facade of supposedly protecting senior citizens.

The best way to tell whether the policies offered by a particular organization are good or bad is to compare their specific terms and prices with those of other policies offered by different insurance companies or health plans. In the final analysis, it is the terms of the policy, not an

organization's good intentions or friendly advertising, that determine the quality of your coverage. The insurance company, not the senior organization, determines your coverage and pays your claims.

Help With Decisions About Medigap and Managed Care

Each state has a program to assist people with Medicare, medigap supplemental insurance and HMOs, and other managed care plans. It is called the State Health Insurance Assistance Program (SHIP), although in some states it may have another, similar name.

SHIP has professional staff and volunteers who are knowledgeable not only about the rules pertaining to Medicare and medigap insurance but also about what policies are available in your state and what HMOs and other managed care plans are available in your local area. SHIP staff can look over particular insurance policies and managed care plans and help you see the strengths and weaknesses of each.

In larger states there are many SHIP offices, and you can reach the office nearest you by calling the state's general toll-free number. In smaller states there may be fewer offices, and you will be referred to a SHIP program at a local senior center or other nonprofit organization.

(See Chapter 12, Section G, for contact information.)

Beware of Mail-Order and Limited-Offer Policies

Beware of policies you receive unsolicited in the mails. Their flashy promises often far outstrip their coverage. If you do become aware of a policy through the mails, and its provisions seem good to you after comparing it with other policies, check the reputation of the company offering the policy. You can get information on the company from your state's insurance department or commission, or from your state or local consumer protection agency.

Also be wary of policies that are offered with short-time enrollment periods. You have likely heard or seen advertisements for insurance that holler: "Limited offer! One month only! Buy now, the greatest offer in years! Once the offer is over, you'll never get another chance at an opportunity like this again! Once-in-a-lifetime offer!"

This is nonsense.

If it's a reputable company with a legitimate policy to offer you, the same or similar terms will be available any time—although you must keep in mind your own six-month open enrollment period after you sign up for Medicare Part B. These advertising slogans are just another way insurance companies have of pressuring you into buying a policy without first carefully considering and comparing its terms.

Most companies permit you to look over your policy and carefully examine its terms for ten days before you are obligated to keep it. If you decide you don't want the policy—for any reason—you can return it within ten days to the company or to the insurance agent you bought it from. You'll be owed a refund of all the money you have paid up to that point. And if you are buying a new medigap policy to replace one you already have, you are legally entitled to 30 days to review the new policy to decide whether you want to keep it. You can cancel it without penalty at any time during those 30 days.

3. Only One Medigap Policy Required

You need only one policy to supplement your Medicare coverage—and it is illegal for an insurance company to sell you a health insurance policy that duplicates coverage you already have with a medigap policy.

When you apply for a medigap policy, you will be asked to provide information concerning any health insurance policies you have. This gives written notice to the seller of your policy—insurance agent, broker, or company representative—about your existing insurance so that you will not be held responsible for paying for duplicate coverage if the insurer mistakenly sells it to you.

If you already have medigap insurance but want to replace it with a new policy, some rules help protect you while you make the change.

Discounts for the “Healthy”

Some insurance companies offer extra discounts on medigap policies for people they consider to be better risks than others. For example, women may be offered lower premiums than men because women tend to remain healthier longer, meaning the insurance company collects more premiums before having to pay out on claims. For the same reason, non-smokers are also frequently offered discounts.

You may also be able to reduce your premiums if you have been free of any serious illness or condition and are willing to prove it by undergoing what is called medical underwriting—a screening process during which the insurance company examines your medical history to see whether you are likely to cost them a lot of money in the near future. If the screening shows that you have had no serious illnesses or medical conditions over the previous ten years, you may be able to purchase the policy at a significantly lower premium than if you had bought it without first being medically screened. Ask the insurance company whether they offer this sort of discount.

4. Replacement Policies

If you are considering replacing your existing policy with a new one, there are a number of things to keep in mind.

First, even if your new policy would ultimately provide better coverage, it may have a preexisting condition exclusion that would deny you coverage for up to six months after you switched policies. If you have been treated in the previous six months for any serious medical condition that might require further treatment in the near future, don't cancel a basically good policy for one that is only slightly better.

Second, unless you are signing up within the first six months following your enrollment in Medicare Part B, the new insurance company from which you applied for coverage might reject you if you have had serious medical problems in the recent past. Don't cancel your old policy until you have been given written notice from the insurance company—not just from the agent or broker who sold you the policy—that your new policy is in effect.

When you apply for a replacement policy, you must sign a statement agreeing that you will drop your old policy when the new one takes effect. The law gives you a review period within which to decide between the old and new policies. Once you have received written notice of your acceptance in the new insurance plan, and you have been given a written copy of the new policy, you have 30 days to cancel either the new policy or the old one.

Dread Disease Policies: A Dreadful Idea

A few insurance companies offer policies that do not provide medigap supplemental coverage but provide particularized health coverage that may overlap some with medigap policies and even Medicare coverage itself. Most of these policies cover treatment for a specific disease and are known as indemnity or “dread disease” policies. They are often solicited over the phone or by direct mail and are offered at low monthly premiums.

One of these policies may initially sound promising if it covers a particular disease—for example, a specific type of cancer—for which you have a high risk. However, close examination of these policies usually shows them to be a waste of money. They pay only a small, set amount of money for each day you are hospitalized or for each medical treatment for the specific disease, usually far less than the Medicare deductible or coinsurance that a medigap policy would pay.

And because they pay only when you are treated for the specific disease, you wind up needing to carry a medigap policy anyway to cover all medical bills not related to this particular disease. Or if you don't carry a medigap policy, you will be responsible for paying out of pocket for all medical bills not covered by this specific-disease policy. Either way, these policies are a bad investment.

State Departments of Insurance: Phone List

State	Department of Insurance Phone Number	State	Department of Insurance Phone Number
Alabama	334-465-2515	Montana	406-444-2040
Alaska	907-269-7900	Nebraska	800-833-0920
American Samoa	808-586-2790	Nevada	702-687-7650
Arizona	800-325-2548	New Hampshire	603-271-2261
Arkansas	501-371-2600	New Jersey	609-292-5360
California	213-927-4357	New Mexico	505-827-4601
Colorado	303-894-7499	New York	800-342-3736
Connecticut	860-297-3800	North Carolina	800-546-5664
Delaware	302-577-3119	North Dakota	701-328-2440
Florida	850-922-3100	Ohio	614-644-2658
Georgia	404-656-2070	Oklahoma	405-521-2828
Guam	808-586-2790	Oregon	503-947-7980
Hawaii	808-586-2790	Pennsylvania	717-787-2317
Idaho	208-334-4250	Puerto Rico	787-722-8686
Illinois	217-782-4515	Rhode Island	401-222-2223
Indiana	317-232-2395	South Carolina	803-737-6150
Iowa	515-281-5705	South Dakota	605-773-3563
Kansas	785-296-3071	Tennessee	615-741-2176
Kentucky	800-595-6053	Texas	512-463-6464
Louisiana	800-259-5300	Utah	801-538-3805
Maine	207-624-8475	Vermont	802-828-2900
Maryland	410-333-2521	Virgin Islands	340-774-7166
Massachusetts	617-521-7794	Virginia	800-552-7945
Michigan	517-335-4978	Washington	800-562-6900
Minnesota	612-296-6848	Washington, DC	202-727-8000
Mississippi	800-562-2957	West Virginia	304-558-3386
Missouri	800-726-7390	Wisconsin	800-236-8517
		Wyoming	307-777-7401



Medicare Managed Care Plans

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Medicare managed care plans—now called Medicare Advantage—fill gaps in basic Medicare, as do medigap policies. But the two systems operate in different ways. As explained in Chapter 13, medigap policies work alongside Medicare: medical bills are sent both to Medicare and to a medigap insurer, and each pays a portion of the approved charges. Medicare managed care, on the other hand, provides all the coverage itself, including all basic Medicare coverage and other coverage to fill the gaps in Medicare coverage. The extent of coverage beyond Medicare, the size of premiums and copayments, and decisions about paying for treatment are all controlled by the managed care plan itself, not by Medicare. (See the charts in Section C, below, to help compare specific policies.)

There are two widely divergent views of managed care. To some, it is an economical way to provide health care. To others, it is an insurance industry attack on access to quality health care. And both views are correct. In return for coverage beyond basic Medicare, managed care plans charge a low monthly premium—or none at all—and small copayments. But they also restrict in several ways the patient's choices about health care services. And they pressure doctors to limit treatments and the length of hospital stays for their managed care patients.

If you are considering a Medicare managed care plan, you must decide whether any of the plans available in your area offer adequate care at an affordable cost.

You'll also need to assess the risks associated with Medicare managed care plans. They're not as stable as they look. In the past several years, Medicare managed care plans have been stam-

peding away from their promise to provide greater coverage at lower cost. Between 1998 and 2004 alone, more than two million seniors were dropped from Medicare managed care plans that stopped serving the areas where they lived. And millions of others found their premiums skyrocketing, their copayments doubling or tripling, and their coverage shrinking, particularly for prescription drugs.

The Medicare Modernization Act of 2003 increased reimbursement rates to Medicare managed care plans by about 10%. With this new, enormous infusion of cash, the managed care plans are supposed to reduce premiums or copayments, enhance benefits, expand their provider networks, or return to areas where they had abandoned service. Unfortunately, there are few concrete standards by which these changes are to be measured, and little government oversight to ensure that the managed care plans use the money the way they are supposed to. Also, there is no requirement that the managed care plans continue these consumer-friendly adjustments in the future. So, the trend of managed care plans increasing their copayments, reducing their benefits, and leaving some areas altogether may well resume in the near future.

Not only do you risk your plan disappearing or becoming far more expensive, but if you choose to return to regular Medicare, your chance to buy a medigap insurance policy (as discussed in Chapter 13) may be much more limited.

To find out the recent history of a particular managed care plan—whether it has dropped patients or hiked costs, for example—call your local SHIP counseling office (see Chapter 12, Section G, for contact information) or your state department of insurance (see Chapter 13 for contact information). If you are dropped from a

managed care plan, your alternatives and when you must exercise them are explained in Section D, below.

Joining Managed Care Means Leaving Medicare

If you join a Medicare managed care plan, you leave the Medicare program altogether. The insurance company that runs the managed care plan gets a monthly payment from Medicare on your behalf. The plan then approves or denies all of your medical coverage. If it denies coverage, it also decides any appeals.

If you leave a managed care plan, you are always permitted to rejoin traditional Medicare. But if you return to Medicare after the first year following your initial Medicare eligibility, you may find that not all medigap supplemental insurance policies will accept you. And you may be able to join another managed care plan only during open enrollment. (See Section D, below, for more on your rights when switching coverage.)

A. The Structure of Managed Care

The basic premise of managed care is that the member-patient agrees to receive care only from specific doctors, hospitals, and others—called a network—in exchange for reduced overall health care costs. There are several varieties of Medicare managed care plans. Some have severe restrictions on consulting with specialists or seeing providers from outside the network. Others

give members more freedom to choose when they see doctors and which doctors they may consult for treatment. Generally, more choice translates into higher cost.

I. Health Maintenance Organization (HMO)

The HMO is the least expensive and most restrictive Medicare managed care plan. There are four main restrictions.

a. Care Within the Network Only

Each HMO maintains a list—called a network—of doctors and other health care providers. The HMO member must receive care only from a provider in the network, except in emergencies.

If the plan member uses a provider from outside the network, the plan pays nothing toward the bill. And because a plan member has technically withdrawn from traditional Medicare by joining managed care, Medicare pays none of the bill, either. The plan member must pay the entire bill out of pocket.

Because of this restriction, it is very important to find out whether the doctors and other providers you use are included in the HMO's network. This is particularly true for your primary care physician, who will not only handle routine medical problems but will also decide whether you should be referred for treatment or to a specialist. It is also important to make sure that the hospital in your vicinity, or a hospital you and your doctor prefer to use, is in the network. If all of your doctors and your preferred hospital are in the HMO's network, the restriction may not be as important to you.

However, HMOs and other managed care plans do add and drop doctors and hospitals when they refer too many patients to specialists or spend more of the HMO's resources on patient care than other doctors and hospitals in their area. And doctors' groups and hospitals leave HMOs that become stingy in reimbursing for medical care or authorizing services for their patients. If the plan or your providers decide to cut their ties, you won't be able to continue seeing your regular doctors. So, even if you begin a managed care plan with all the right doctors and hospital, you may later find yourself traveling long distances to get to a new hospital and searching for new doctors, or searching for a new managed care plan or medigap policy.

This instability of managed care plans makes it important for you to discuss with your doctors any particular HMO you are considering. Ask whether your doctor has experienced problems with the plan, particularly with approval of treatments, referrals to specialists, or early release from inpatient hospital care. It may be useful to talk with the billing office staff at your doctor's office, since they have daily contact with the insurance company bureaucracy.

Some doctors are uncomfortable speaking with patients about insurance companies. But responsible physicians will at least tell you if their offices are considering dropping a particular plan altogether.

Emergency and Urgent Care Anywhere

Federal law requires that all plans cover emergency services nationwide, regardless of restrictions they place on the use of doctors and hospitals for routine care. The law also requires that plans pay for covered services you receive from a nonplan provider if the treatment was urgently needed while you were temporarily outside the plan's geographic service area. (See Section B5, below, for more discussion of the extent of your plan's service area.) Urgently needed care means care for an unforeseen illness or injury for which a reasonable person would not wait until they could return home to seek medical help.

This required emergency coverage does not apply to most foreign travel. However, some plans offer such coverage on their own. If you travel or live any part of the year outside the United States but are not covered while abroad, it may be a good idea to buy a temporary policy covering you for the time you are out of the country.

b. All Care Through Primary Care Physician

An HMO member must select a primary care physician from the plan's network. This is the doctor the member must see first for all medical needs. An HMO member may not see other doctors or providers—even from within the plan's network—or obtain other medical services without a referral by the primary care physician. Even if you regularly see a variety of specialists, your primary care physician must refer

you to those doctors. You may not simply make an appointment to see them on your own.

This system encourages the primary care physician—who is paid less than a specialist by the plan—to take care of medical problems that don't absolutely require a specialist. Because of the hassle of the extra step, it also discourages the plan member from seeking specialist care.

This restriction is a significant reason that managed care is cheaper for insurance companies than traditional fee for service policies. Since many seniors require specialist care, this restriction is also a reason that many of them reject HMO coverage in favor of medigap insurance or less restrictive types of managed care.

c. Prior HMO Approval of Some Services

HMOs require that your primary care physician or other network physician obtain prior approval from the plan for certain medical services the doctor may want to prescribe. If plan administrators do not believe a service is medically necessary, or believe service from a nonspecialist or other less expensive treatment would do just as well, they may deny coverage for that prescribed service.

d. Limited Appeal Rights

Within every HMO plan, a member has a limited right to appeal the plan's decisions. But for the vast majority of HMOs, reviewers who work for the HMO hear the appeal. There is no review by outside experts, and no appeal to Medicare; only a few HMOs have outside review panels that consider appeals in serious cases. (See Section B4, below, for more on review processes.)

2. HMO With Point-of-Service (POS) Option

A few HMOs have a significant wrinkle that makes them more attractive—and more expensive—than standard HMO plans. These plans offer what is called a point-of-service option. This option allows a member to see physicians and other providers who are not in the HMO's network, and to receive services from specialists without first going through a primary care physician.

However, if a member does go outside the network or sees a specialist directly, the plan pays a smaller part of the bill than if the member had followed regular HMO procedures. The member pays a higher premium for this option than for a standard HMO plan, and a higher copayment each time the option is used.

3. Preferred Provider Organization (PPO)

Although it has a different name, the PPO works the same as an HMO with a point-of-service option. If a member receives a service from the PPO's network of providers, the cost to the member is lower than if the member sees a provider outside the network.

PPOs tend to be more expensive than standard HMOs, charging both a monthly premium and a higher copayment for nonnetwork services. However, many people find that the extra flexibility in choosing doctors is an important comfort to them, and therefore worth the extra money.

4. Provider Sponsored Organization (PSO)

The PSO is a group of medical providers—doctors, clinics, and a hospital—that skips the insurance company middleman and contracts directly with patients. As with an HMO, the member pays a premium, as well as a copayment each time a service is used.

Some PSOs in urban areas are large conglomerations of doctors and hospitals that offer considerable choice in providers. But many PSOs are small networks of providers that contract through a particular employer or other large organization, or that serve a rural area that has no HMO.

B. Choosing a Medicare Managed Care Plan

To evaluate a managed care plan, get a complete written explanation of its coverage, costs, and procedures. These are usually contained in a printed brochure called a Summary of Benefits. Also, get a chart showing premiums and copayments. Compare that written information with each important category discussed in this chapter.

If you do not understand exactly what the coverage, costs, and procedures are, ask a plan representative to point out where they are explained in the written information. If you can't get an important piece of information in writing, don't join the plan.

I. Choice of Doctors and Other Providers

For many people, the most important factor in choosing a Medicare HMO or PSO is whether the doctors, hospital, and other providers they already use and trust are in the plan's network of providers. If the people and places you prefer for care are in the network, the tight restrictions of HMOs and PSOs may not have much effect on you, at least for the foreseeable future. But if they're not, you are faced with finding new doctors, which is never an easy or comfortable process. And you might have to use a hospital that is more distant from your home, leaving you a little less secure.

The problem is not quite as great with PPOs, or HMOs with a point-of-service option. These plans permit you to use providers who are not in the plan's network. So, if you want to continue with a particular doctor or provider who is not in the network, you may do so, but with a higher copayment each time you use the non-network provider. If you are treated by non-network doctors very often, the extra payments may wind up canceling out the cost advantage of managed care.

Help With Managed Care Choices

Seniors finding their way through the managed care maze can get help from the State Health Insurance Assistance Program (SHIP). SHIP is funded by a combination of government grants and private donations and has no connection to the health care or insurance industries. SHIP provides free counseling to seniors about Medicare managed care plans and medigap policies. Local staff can help you compare plans and policies. They can also tell you about other seniors' recent experiences with specific plans and policies.

To find the SHIP office nearest you, call the toll-free line for your state's central SHIP office listed in Chapter 12, Section G.



You can compare plans online. Medicare's official website at www.medicare.gov has a link called "Medicare Personal Plan Finder." This will give you names, contact information, details of costs, and the extent of coverage for managed care plans offered in your zip code area. In addition, it offers patient satisfaction ratings and statistics on how many people left each plan. Always double-check such information with your local SHIP office, however, since it may be out of date and it doesn't mention how many people were dropped by the plan. Also be sure to check with the managed care plan itself for the finer print and the most up-to-date terms of its policies.

2. Access to Specialists and Preventive Care

The requirement that you must visit your primary care physician to obtain specialist referrals is one of the main customer objections to managed care. Try to learn how difficult it is to get a referral to a specialist with any plan you are considering, using the suggestions in this section.

a. Covering Referrals

Your primary care physician refers you for testing, laboratory work, and treatment by specialists. Speak with your primary care doctor and other physicians you see regularly about their experiences with a particular plan. Does the plan often overrule the doctor's recommendation? Has the plan set guidelines for the doctors that might affect their ability to send you for treatment?

b. Access to Specialists

Medicare rules require managed care plans to develop a specific treatment plan for patients with a complex or serious condition, such as heart disease, cancer, or kidney failure. The plan must outline what specialists you require, and it must allow you to see them without a referral from your primary care doctor. If you have a condition that requires care by specialists, find out from the plan whether your condition is considered sufficiently serious or complex to permit direct access to your specialists.

c. Preventive Care Options

Under Medicare rules, a managed care plan must permit members to obtain routine preventive women's health care screening from a gynecologist without first seeing a primary care physician. It must also permit a member to obtain Medicare-mandated mammograms without a referral. Find out from a managed care plan what other preventive care services—such as annual physical exam, prostate screening for men, cholesterol testing, or hearing exams—the plan permits members to schedule on their own.

Now You Get Coverage, Now You Don't

Unlike medigap insurance policies, the government does not regulate managed care plan coverage except to insist that the plans offer at least basic Medicare benefits. Nor is there any regulation of premiums and copayments. What this means is that managed care plans are free to change coverage and charges at any time.

To compete with other insurance, your plan might expand coverage. In recent years, for example, short-term custodial care and overseas travel coverage have been added to many plans, although most charge an added premium for these “extras.”

But plans will just as often cut back on coverage. In some plans, benefits are shifted from no-premium plans to deluxe plans with a premium. Raising copayments for specific services—particularly prescription drugs—is also common, as is restricting access to certain medications.

3. Total Cost

Many managed care plans charge no premium to members. Other plans charge a relatively small premium—especially PPOs, and HMOs with point-of-service option or “deluxe” coverage, such as unlimited prescription drugs. Usually, these premiums are lower than for medigap policies.

But premiums don't tell the whole story. You must add up other costs to see if a managed care plan is a better financial deal for you than medigap.

a. Copayments

A copayment is the amount a plan member must pay out of pocket for each visit, service, or drug prescription. There is usually no copayment for hospital stays, surgery, laboratory work, skilled nursing care, or home health care that would be covered by basic Medicare. But there is a copayment for most doctor visits, usually \$5 to \$15. Many older people consult with several doctors fairly frequently. If you do, then the copayments can add up quickly.

b. Prescription Drug Copayments

The most expensive out-of-pocket medical cost for many seniors is prescription drugs. Managed care plans all cover some amount of prescription medication. But they require patient copayments and impose restrictions that vary considerably depending on the category of drugs you use.

Managed care plans separate drug coverage and copayments into several categories—each of which carries different cost restrictions. Some

HMOs now refuse to cover brand-name drugs if a generic alternative is available.

- **Generic versus brand name.** Managed care plans encourage use of generic drugs, usually by offering much lower copayments, such as \$5 per generic prescription compared to \$15 to \$25 for brand name drugs. Other plans place a yearly limit on the amount they will spend for brand-name medication. If you frequently use and strongly prefer a particular brand-name drug, this price difference can be important.
- **Formularies.** Most managed care plans maintain a preferred list of drugs, called a formulary. With some managed care plans you may use drugs not on the formulary, but for a higher copayment. With other plans, if you use a drug that is not on the formulary, the plan pays nothing at all.

It is best to pick a plan that pays something for nonformulary drugs, because managed care plans often change the drugs in their formulary. If a brand-name drug you use is dropped from the list in favor of a cheaper generic, the plan will still pay something for the brand-name drug if you choose to continue using it.
- **Mail order drugs.** Many people who take regular medication have found that they can get it cheaper by ordering large quantities through a mail order drug company instead of using a local pharmacy. Mail order drugs are cheaper for managed care plans, too. Some plans offer lower copayments for medicines ordered this way.

Tracking Membership Satisfaction

You will not learn about member complaints from a managed care plan. But it pays to see whether many members complain about crucial services. Most complaints are based on the plan having:

- rejected referrals to specialists
- ordered early discharge for hospital inpatients
- dropped coverage in certain geographic areas
- dropped doctors and hospitals from the network
- raised copayments
- switched drugs on the plan's formulary, or
- dropped extra coverage.

Your state Department of Insurance or Department of Corporations is charged with monitoring managed care plans, but their efforts will probably be spotty. Some keep good track of complaints and make them public. But many keep poor track of complaints or refuse to release information about them.

An excellent and free source of information about managed care plans is the State Health Insurance Assistance Program. To find your local office, call the central SHIP office in your state, listed in Chapter 12, Section G.

4. Review Process

About 30% of Medicare managed care patients report having been denied coverage for treatments their plans deemed to be medically unnecessary or experimental. And if you are denied coverage for a treatment or service, Medicare will not help you. The appeals procedure is run by the plan. The prospect of having your wishes and those of your doctor overruled by the insurance company is always enraging. When the treatment is for a serious illness, the plan's rejection can be devastating.

Before joining any managed care plan, explore its appeal or review process. The procedures should be explained in the Summary of Benefits booklet the plan gives to potential members. If the review process is not fully explained, request written information from a plan representative.

a. What the Law Requires

All Medicare managed care plans are legally required to put a denial of coverage in writing within 14 days of a request for coverage—and within 72 hours of a request if the treatment involves urgent care.

If you appeal the denial, the plan must decide the appeal within 30 days of the time the appeal is filed, or within 72 hours if the condition is urgent. If the denial is based on a determination that the treatment or referral is not medically necessary, the law requires that any review of the decision be made by a physician with expertise in the area of medicine involved.

b. Who Makes the Decisions

Beyond the few legal controls described above, the process by which decisions are reviewed is completely up to the plan. And the most important element of that process may be who does the reviewing. There are three types of review:

- **Internal review only.** Panels of managed care plan doctors and health care managers—medical accountants, basically—decide appeals. These panels are less likely than an external reviewer to reverse a denial of treatment. Unfortunately, most managed care plans use only internal review boards.
- **External review chosen by plan.** In cases where care has been denied as not medically necessary or as experimental, some plans permit external review. However, most plans choose and pay the outside reviewer, which raises concerns about the impartiality of the review process.
- **Independent external review.** Independent review boards are best for plan members. Although consumer groups are pushing the managed care industry hard in this direction, truly independent reviews are still rare.

5. Extent of Service Area

Consider the extent of a plan's service area, particularly if you live in a rural or spread-out suburban area. If the service area is not broad enough to include a good selection of specialists, you may find your future care choices limited.

Also, see whether the plan has what are called extended service areas. Some plans permit you to arrange medical care far from your home if you travel frequently or spend a regular part of the year away from its primary service area. This allows you to take care of nonurgent medical needs even if you are not at your primary residence.

6. Other Plan Features

In addition to the key features of managed care plans, many plans offer a variety of other features beyond basic Medicare coverage. The following extra benefits are either minor services provided by some plans or major medical expenses for which some plans pay a small portion. If you are likely to use any of these benefits, the plan that offers them may be more attractive to you.

a. Short-Term Custodial Care

Following an injury, surgery, or serious illness, you may not be strong enough to take care of yourself, but may not require skilled nursing care. Instead, you might need custodial care—help with dressing, bathing, eating, and other regular activities of daily living.

Custodial care is not covered at all by Medicare, unless you are already receiving skilled nursing care or therapy. But some managed care plans do offer coverage for short-term custodial care, either at home from a certified home health care agency or in a certified nursing facility.

Such plans usually limit the number of home care visits or days you can spend in a nursing facility, and charge copayments as well as a separate premium for the coverage. Despite these limitations, this can be valuable added coverage, because almost every senior can use this kind of care at some point.

b. Medical Equipment

By way of reminder, Medicare pays 80% of the amount it approves for doctor-prescribed medical equipment, such as wheelchairs, hospital beds, ventilators, and prosthetic devices. But the recipient is responsible for 20% of the approved amount, plus anything above that amount if the equipment company does not accept Medicare assignment. (See Chapter 11, Section E, for more on Part B insurance rules.) Some managed care plans pay the full cost of prescribed medical equipment, although it must be purchased or rented from a provider in the plan's network.

c. Chiropractic Care, Acupuncture, and Acupressure

Medicare pays for a very limited amount of chiropractic care, and pays nothing at all for acupuncture or acupressure treatment. Some managed care plans cover a greater amount of chiropractic care. And a few recognize the value of acupuncture and acupressure and pay for some of the cost.

Treatments must be received from providers in the plan's network, and a copayment is almost always charged for each visit. However, if you regularly use one of these treatments and your practitioner happens to be in the plan's network, this coverage can be a good money-saver.

d. Routine Physical Exams

Unlike Medicare, virtually all managed care plans pay completely for at least one routine physical exam per year. Managed care plans have figured out that it is cheaper for them—not to mention healthier for members—if illnesses are detected early during routine physical exams.

e. Foreign Travel Immunizations and Emergency Coverage

Many people travel abroad to visit family; others hope to do some foreign traveling during retirement. Medicare provides no coverage for medical costs incurred outside the United States, nor do most managed care plans. But a few plans offer coverage for emergency care while abroad. And some also offer free or low-cost immunizations for foreign travel. If you plan on traveling abroad frequently or for long stays, this coverage can be valuable.

f. Eye Examinations and Glasses

Medicare covers only eye examinations and optometry services that are necessary because of an eye disease or other medical conditions. It does not pay for any part of regular vision testing or for eyeglasses or contact lenses, except after cataract surgery. A number of managed care plans offer some kind of bonus vision coverage, although none of them pays the full cost of glasses.

Some plans cover one eye examination every two years from a network optometrist and offer a set annual amount—usually \$50 to \$100—toward prescription lenses. Instead of a set amount, other plans offer discount examinations, lenses, frames, and contacts. These plans, too, include only network optometrists; they often simply hook you up to an existing chain of optometry clinics and provide you with a discount.

g. Hearing Tests and Hearing Aids

Some managed care plans offer a free regular hearing exam, plus discounts on hearing aids. As with other managed care coverage, the care must be obtained from a hearing center that is connected to the plan's network.

h. Dental Work

Some managed care plans offer discounts on dental work. The discounts usually include a low copayment for cleaning and examination and up to a 35% reduction in the cost of other services. The networks of dentists are usually quite limited, however. Finding a network dentist with whom you are comfortable is the key to making this extra coverage worthwhile.

i. After-Hours Advice and Treatment

People don't always become ill during regular office hours. But visiting an emergency room can be a miserable—and often unnecessary—experience. Some managed care plans maintain 24-hour phone lines staffed by experienced nurses offering medical advice that can help you stay out of an emergency room. Other plans—usually provider-sponsored organizations or individual groups of doctors within a larger HMO—even maintain evening and weekend clinics. There, you can consult with one of the plan's doctors, usually for a lower copayment and less stress than a visit to an emergency room.

j. Chronic Disease Management and Wellness Programs

The present insurance-run managed care industry recognizes how much money it saves by monitoring and managing chronic conditions and offering programs to improve general

health. As a result, many managed care plans offer free or low-cost educational and monitoring programs to help people with chronic illness keep their conditions under control. Some programs include blood pressure and cholesterol education for heart patients, diabetic classes to control blood sugar levels, and classes for Parkinson's patients to reduce their risk of falls. Some plans offer programs to help people lead healthier lives, such as nutrition and exercise programs to improve flexibility and cardiac health, to help lose weight, and to quit smoking.

C. Comparing Medigap and Managed Care Plans

After you have located several medigap and managed care plans that seem to fit your needs and budget, the best way to compare them is to view their costs and coverage side by side. Refer to the chart below for a side-by-side comparison of the major benefits of medigap and managed care plans. Then, use the next chart to help you compare the actual plans you are considering.

Comparing Medigap to Managed Care

	Medigap Plans	Managed Care Plans
Choice of Doctor and Providers	As long as doctor or other provider accepts Medicare, a medigap policy will cover whatever Medicare does.	Restricted to doctors and providers in the network. PPO and some HMO options allow non-network providers at higher cost.
Access to Specialists	As long as specialist accepts Medicare, a medigap policy will cover whatever Medicare does.	Must get referral from primary care doctor. Limited direct access available for some serious conditions.
Premiums	Varies widely, with higher cost for plans with more services. Policy A: \$50–\$150/month. Policies B–G: \$75–\$200/month. Policies H–J: \$150–\$300/month.	No premium for basic HMO. Member must pay Medicare Part B. Broader coverage or more provider choices may cost between \$25–\$100/month.
Copayments	No copayments for services.	Require copayment for most services, currently \$5–\$25 per visit.
Prescription Drugs	No payment for self-administered medication in most plans. Policies H, I, and J pay 50%, with annual limit of \$1,250 for H and I plans. J plan has \$3,000 limit after \$250/year deductible.	Copayment of \$5–\$25 per drug prescription. Generally less expensive than under medigap policies. Amount depends on use of generic or brand name and specific plan formulary list.
Treatment Approval	Automatic if service is covered by Medicare.	Coverage denied if treatment is considered medically unnecessary or experimental.
Geographic Mobility	Most policies may be used wherever you obtain Medicare-covered services in the United States.	Nonemergency coverage limited to specific geographical area. Some plans offer care away from home. All plans must cover emergency care anywhere.
Emergency Care Overseas	Covered by plans C–J.	Some plans cover, but for a higher premium.
At-Home Recovery	Covered by plans D, G, I, and J, but only if also receiving skilled nursing care at home.	Some plans cover, but for a higher premium and copayment.
Preventive Health Screenings	Limited coverage in plans E and J.	Most plans offer physical exams and free or low-cost screenings, although premiums and copayments may be higher.
Eye Exams and Glasses	No, unless connected to illness or injury.	Most offer limited discounts on exams and lenses.
Hearing Exams and Aids	No, unless connected to illness or injury.	Most offer limited discounts on exams and hearing aids.
Dental Discounts	No.	Some offer limited discounts.
Wellness Programs	No.	Many offer a variety of low-cost or free wellness programs, including heart-healthy education, weight loss, quitting smoking, and cholesterol management.
Chiropractic Care	Only if covered by Medicare.	Some offer broader coverage than Medicare.

Comparing Medigap Policies and Managed Care Plans

		Plan Name	Plan Name	Plan Name	Plan Name	Plan Name
		_____	_____	_____	_____	_____
Cost (monthly premium)						
Copayments (amount I must pay per visit)						
Other Medicare gaps left unfilled						
Is there coverage outside the plan?	Yes					
	No					
Cost of care outside the plan						
Prescription drug coverage	Copayment					
	Annual limit					
Dental care covered	Yes					
	No					
Choice of dentists	Yes					
	No					
Short-term custodial care	Yes					
	No					
Eyeglasses	Copayments					
	Visits per year					
Other services:						
Hearing exam	Yes					
	No					
Chiropractic	Yes					
	No					
Foreign travel	Yes					
	No					
Exercise program	Yes					
	No					
Other	Yes					
	No					

D. Your Rights When Joining, Leaving, or Losing Managed Care Coverage

Insurance companies offering Medicare managed care plans are free to charge whatever they want in premiums and copayments. They alone decide what types of medical care to cover, although they must provide the same basic services that Medicare does. Moreover, they may offer a Medicare managed care plan one year and withdraw it the next—leaving its beneficiaries without coverage. Managed care plans do this county by county around the nation, deciding which spots are profitable enough for them and dropping seniors in places that don't measure up.

Despite this general corporate freedom for Medicare managed care insurance companies, they must follow a few rules concerning people's rights to join or to leave their plan.

I. Joining in the First Six Months After Enrolling in Medicare

Within the first six months of enrolling in both Part A and Part B of Medicare, you have an unqualified right to join any Medicare managed care plan that operates in the county of your primary residence. This means that the plan must accept you without any medical screening and on the same terms and conditions as anyone else of your age, regardless of your medical history or physical condition.

2. Joining During a Plan's Open Enrollment Period

Every Medicare managed care plan must have at least one month every year of what is called "open enrollment"—meaning that during that time anyone eligible for Medicare may join the plan regardless of their medical history or condition. This month is usually November, with coverage to begin the following January 1. But many plans have more than one month per year of open enrollment. A few plans even have continuous open enrollment.

3. Leaving the Plan

As of 2005, the rules for leaving a Medicare managed care plan are the same as for joining one. You can leave the plan—with 30 days' written notice—but only during the plan's open enrollment period. It doesn't matter whether open enrollment lasts one month, several months, or is continuous.

4. Joining When Dropped From Another Managed Care Plan

If you have been enrolled in a Medicare managed care plan and that plan notifies you—by October 1—that at the end of the year it is dropping out of Medicare coverage in the county where you live, you have several options. You may return to original Medicare coverage, and you are guaranteed the right to supplement that coverage by purchasing one of several medigap insurance policies. (See Chapter 13, Section D, for discussion of choosing a Medigap policy.)

Or, you may enroll in any other Medicare managed care plan being sold in your county, if the plan has not reached a preapproved membership limit. You have this right to join any Medicare managed care plan during a “Special Election Period” from October 1 through December 31. You may have your coverage begin on November 1, December 1, or January 1, as long as you apply before the date you choose.

5. Joining When Moving to a New Geographic Area

Managed care plans serve only a specific, small geographic area, usually a single county. If you move from that area, you lose the right to continued coverage with your Medicare managed care plan.

If you want to remain in managed care, you must apply to a Medicare managed care plan serving your new community. You have a guaranteed right—meaning without any medical screening—to join a plan there during that plan’s “open enrollment” period (see Section 2, above). The exception is if you are still within the first six months after enrolling in Medicare, in which case you may join any plan in the area at any time (see Section 1, above).





Medicaid and State Supplements to Medicare

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When all types of medical expenses for older Americans are added up, Medicare pays for only about half of them. This leaves most people with considerable worry about how they will cover the rest. One approach is to buy private Medicare supplement insurance; another is to enroll in a managed care health plan. But many people cannot afford such insurance or health plans. For a number of low-income people, fortunately, there are some alternatives.

If you have a low income and few assets other than your home, you may qualify for assistance from your state's Medicaid program. Medicaid pays not only Medicare premiums, deductibles, and copayments, it also covers some services Medicare does not.

If you have too high an income or too many assets to be eligible for Medicaid, you may still qualify for one of several Medicaid-administered programs to help you meet medical costs: Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI). (See Section F, below, for a discussion of these programs.)

A. Medicaid Defined

Medicaid's purpose is to help pay medical costs for financially needy people. The program was established by the federal government and is administered by the individual states. Medicaid operates in addition to Medicare to pay for some of the medical costs Medicare doesn't cover.

The basic difference between Medicare and Medicaid is simple: Medicare is available to most everyone age 65 or over, regardless of income or assets, while Medicaid is available to people of any age who are financially needy. Just how "needy" you must be in order to get Medicaid is up to the state in which you live.

There are currently more than 30 million people who receive some form of Medicaid assistance; about one-fourth of them are also on Medicare. (See Chapter 11, Section B, for a fuller comparison of the programs.)

There are federal guidelines for Medicaid, but they are fairly broad. Each state is permitted to make its own rules regarding eligibility, coverage, and benefits. This chapter explains the basic eligibility and coverage rules of Medicaid, and indicates where eligibility standards may be higher or lower than the basic levels.

B. Who Is Eligible

Generally, states use one of two ways to determine who is eligible for Medicaid. One way is to base eligibility on income and assets alone ("Categorically Needy"). The other is to base eligibility on income and assets plus medical costs ("Medically Needy").

I. Categorically Needy

To qualify for Medicaid as Categorically Needy, your income and assets must be at or below certain dollar amounts. Most states use the same income and asset limits set by the federal

Supplemental Security Income, or SSI, program. Other states establish their own Medicaid limits.

a. SSI-Based Standards

In most states you can automatically receive Medicaid if you are eligible for SSI assistance. To be eligible for SSI, you usually can't earn more than \$300–\$500 per month, or \$500–\$700 for a couple. Also, you can't possess cash and other assets of more than \$2,000 for an individual and \$3,000 for a couple.

Fortunately, a number of important—and high-priced—assets are not counted in the SSI eligibility calculation. You may own your own home of any value; a car worth up to \$4,500; engagement and wedding rings; household goods; life insurance; and a burial fund. (For details of SSI eligibility rules, see Chapter 6.)

b. State Standards

States have gone in all directions when establishing their own Medicaid standards. In a few states, the standards are slightly less difficult to meet than SSI standards. In some others, the standards are stricter, including a dollar limit on the value of your home and lower limits on the values of your automobile and other property.

To find out your state's standards, contact your local county department of social services or department of welfare. If you are anywhere close to the eligibility limits in your state, consider applying for Medicaid or a state Medicare supplement (described in Section F, below) as well.

2. Medically Needy

What if your income and assets are higher than the SSI or other state limits, but your medical expenses cancel much of this out? You may be what's called "Medically Needy," and eligible for Medicaid coverage in some states. Medically Needy means your income and assets are over the eligibility levels for your state but your current or expected medical expenses will reduce your income or assets to eligible levels.

This process of subtracting actual medical bills from income and assets is called "spending down," in Medicaid slang. This is because medical bills would force you to spend your extra money down to the point that you would meet eligibility levels.

The following states offer Medicaid coverage to Medically Needy people:

Arizona	Montana
Arkansas	Nebraska
California	New Hampshire
Connecticut	New Jersey
District of Columbia	New York
Florida	North Carolina
Georgia	North Dakota
Illinois	Oklahoma
Iowa	Pennsylvania
Kansas	Texas
Kentucky	Utah
Louisiana	Vermont
Maine	Virginia
Maryland	Washington
Massachusetts	West Virginia
Michigan	Wisconsin
Minnesota	

Example: Roberta's income is low, but her savings are \$2,000 more than what is allowed to qualify for Medicaid as Categorically Needy by the rules in her state. However, surgery, home nursing care, physical therapy, and medication have left Roberta with medical bills of almost \$3,000 (not paid for by Medicare). Roberta's state offers Medicaid coverage to the Medically Needy. If she paid her \$3,000 medical bills, she would be spending her savings down to a level that would meet the Medicaid standards. Instead of forcing her to spend that money and be reduced to Medicaid savings levels, Roberta qualifies immediately for Medicaid, which will pay the bills.



If your income and assets are a little too high for Medicaid, the government may help through other programs. If your income and assets are low but slightly too high for you to be eligible for Medicaid in your state, you may still be eligible for state Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI) benefits. These programs help meet medical costs not paid for by Medicare. (See Section F, below, for details.)

Medicaid Through Managed Care

In many areas around the U.S.—it varies from county to county—a state's Medicaid program offers coverage to Medicare enrollees through a local HMO or other managed care plan. These Medicaid/Medicare programs require that medical services be received from participating doctors, hospitals, clinics, and other medical providers. (See Chapter 14, Section A, for more on these program restrictions.) Premiums and most copayments, however, are paid by the county Medicaid program. Each participating managed care plan operates differently. Your county Department of Social Services can tell you whether your county has a Medicare/Medicaid managed care plan, and what its coverage includes. To get help comparing such a managed care plan with standard Medicaid coverage, contact the SHIP office nearest you. (See Chapter 12, Section G, for contact information.)

3. Determining Couples' Income and Assets

In determining your eligibility, Medicaid generally considers your income and assets plus those of your spouse, if you live together. If you are divorced or separated and living apart, your spouse's income and assets are not counted, except to the extent that your spouse is actually contributing to your support.

This rule of considering a spouse's income in determining Medicaid eligibility has had the unfortunate effect of keeping many older couples from marrying. They fear that if they

marry, a serious illness could bankrupt both of them before they would become eligible for Medicaid assistance.

When both become eligible for Medicare, however, this loss of Medicaid may not be as serious. And if they marry, each becomes eligible at age 62 for Social Security dependents benefits based on the other's work record. If one person has earned considerably higher Social Security or civil service benefits than the other, this ability to get dependents benefits may make a considerable difference. (See Chapter 4 regarding dependents and Chapter 9 regarding civil service benefits.) The same is true of Social Security or civil service survivors benefits. Marriage would allow one spouse to claim these benefits when the other dies, and to collect them for life (see Chapters 5 and 9 for details).

4. Financial Help From Friends or Family

The income or assets of your children, other relatives, or friends, even if you live with them, are not considered in deciding your Medicaid eligibility. However, if you receive regular financial support from a relative or friend—cash or help with rent—Medicaid can consider that assistance as part of your income.

Also, if you are living rent-free with children or other relatives and they give you all of your food and clothing, Medicaid could figure out a dollar amount for that support and count it as part of your income. This does not happen frequently. But it is possible that during the application process, the person reviewing your eligibility could visit your home and determine whether you are receiving substantial, regular income in the form of noncash support.

Medicaid When One Spouse Is in a Nursing Home

The Medicaid rule gets a bit tricky when one spouse is in a nursing home while the other spouse remains at home. Most states look only at income in the nursing home resident's name, but some states consider the joint income of both. A monthly allowance is permitted for at-home spouses, who are also allowed to keep their homes and to retain between \$19,000 and \$93,000 in other assets, depending on the state. These figures go up periodically.

However, Medicaid may also place a lien on the home or on other assets in an amount equal to the entire amount Medicaid spends on nursing home care for the spouse. When the at-home spouse dies or sells the house, Medicaid will enforce the lien, taking money that the at-home spouse would otherwise be able to spend or leave to survivors.

To take best advantage of Medicaid coverage for long-term care, it is important to understand these rules and also the alternatives to nursing homes that can serve your needs while preserving as much of your savings as possible.

Long-term care and how it is paid for, including a comprehensive discussion of Medicaid nursing home rules, is covered fully in [Long-Term Care: Home Care, How to Plan & Pay for It](#), by Joseph Matthews (Nolo). See the back of this book for ordering details or go to www.nolo.com.

C. Medical Costs Covered by Medicaid

Medicaid covers the same kinds of services as Medicare and, in most states, also covers a number of medical services Medicare does not. One of its best features is that it covers most long-term care, both at home and in nursing facilities. This includes not only long-term skilled nursing care, but also nonmedical personal care—such as adult day care and at-home assistance with the activities of daily living (ADLs). These are the very needs that force many people into nursing homes and keep them there for years.

Medicaid also pays many of the amounts Medicare does not pay in hospital and doctor bills. Specifically, this means Medicaid pays:

- the inpatient hospital insurance deductible and coinsurance amounts that Medicare does not pay
- the Medicare medical insurance deductible
- the 20% of the Medicare-approved doctors' fees that Medicare medical insurance does not pay, and
- the monthly premium charged for Medicare Part B medical insurance.

I. Services Covered in Every State

In every state, Medicaid completely covers certain medical services, paying whatever Medicare does not. They have to do so—it's a matter of federal law.

These services include:

- inpatient hospital or skilled nursing facility care
- nursing home care in approved facilities
- outpatient hospital or clinic treatment
- laboratory and X-ray services
- physicians' services
- home health care, and
- transportation—by ambulance, if necessary—to and from the place you receive medical services.

2. Optional Services

In all states, Medicaid also covers many other types of medical services (over 30 types, if you add them up). However, state Medicaid programs are not required to cover these optional services, and in some states they may charge a nominal fee for them. (Section E2, below, gives details on fees.)

Almost all states provide the following optional medical services commonly used by older people:

- **Prescription medications.** These are covered in all states, though a small copayment may be charged in some.
- **Eye care.** Standard eyesight exams (every one to two years), plus the cost of eyeglasses.
- **Dental care.** Routine dental care, though the list of dentists whom you're allowed to see may be quite limited; most states also cover the cost of dentures.

- **Transportation.** Nonemergency transport to and from medical care, usually with some sort of van service under contract to the county.
- **Physical therapy.** Most states provide some amount of physical therapy beyond the very limited amount covered by Medicare.
- **Prosthetic devices.** All states cover the costs of medically necessary prosthetics beyond what is paid for by Medicare.

The types and amount of coverage for other optional services vary widely from state to state. However, these other optional services often include chiropractic care, podiatry, speech and occupational therapy, private-duty nursing, personal care services, personal care and case management services as part of home care, adult day care, hospice care, various preventive, screening, and rehabilitative services, and inpatient psychiatric care for those 65 and over.



Coverage changes frequently. Medicaid coverage for optional services changes frequently, with states adding some services and dropping others. Check with your local social services or social welfare office for the latest. You must also find out the terms on which such optional services are offered. Sometimes you can obtain such services only if the care is provided by county or other local health clinics, rather than from a private doctor or clinic of your choice.

D. Requirements for Coverage

Even if a particular medical service or treatment—such as a prosthetic device—is generally covered by Medicaid, you must make sure that the care was prescribed by a doctor, administered by a provider who participates in Medicaid, and determined to be medically necessary.

I. Care Must Be Prescribed by Doctor

The medical service you receive must be prescribed by a doctor. For example, Medicaid will not pay for chiropractic services or physical therapy you seek on your own. And it will pay only for prescription drugs, even if you could get the same or equivalent medicine cheaper over the counter.

For services in which a doctor is generally not involved—such as regular eye exams or dental care—Medicaid may place restrictions on how often you can obtain the service and who can authorize it. And Medicaid will cover some services for those who qualify as Medically Needy only if the care is provided by certain public health hospitals, clinics, or agencies.

2. Provider Must Be Participating in Medicaid

You must receive your treatment or other care from a doctor, facility, or other medical provider participating in Medicaid. The provider must accept Medicaid payment—or Medicare plus Medicaid—as full payment. And if you saw a nonphysician such as a physical therapist or chiropractor, or were visited by a home care agency, that provider must be approved by Medicaid.

Not all doctors and clinics accept Medicaid patients. You can get referrals from your local social welfare office. And before you sign up with any doctor or other provider, ask whether they accept Medicaid payment.

3. Treatment Must Be Medically Necessary

All care must be approved by Medicaid as medically necessary. For inpatient care, the approval process is similar to the one used for Medicare coverage. By requesting your admission to a hospital or other facility, your doctor sets the approval process in motion. You won't need to be involved. In fact, you won't even hear about it unless the facility decides you should be discharged before your doctor thinks you should. (Chapter 12, Section F, discusses appeals procedures for this situation.)

You must get prior approval from a Medicaid consultant before you obtain certain medical services. The rules vary from state to state, requiring prior approval for such services as elective surgery, some major dental care, leasing of

medical equipment, and nonemergency inpatient hospital or nursing facility care.

If a particular medical service requires prior Medicaid approval, your doctor or the facility will contact Medicaid directly. You may be asked to get an examination by another doctor before Medicaid will approve the care, but this does not happen often.

If you have questions about the approval process, discuss it with both your doctor and a Medicaid worker at your local social service or welfare office. Ask what Medicaid considers most important in making the decision about the medical care you are seeking. Relay that information to your doctor, so that the doctor can provide the necessary information to Medicaid.

E. Cost of Medicaid Coverage

Almost all Medicaid-covered care is free. And Medicaid also pays your Medicare premium, deductibles, and copayments. However, there are a few circumstances in which you might have to pay small amounts for Medicaid-covered care.

I. No Payments to Medical Providers

Hospitals, doctors, and other medical care providers who accept Medicaid patients must accept Medicare's approved charges—or the amount approved directly by Medicaid if it is not covered by Medicare—as the total allowable

charges. They must accept as payment in full the combination of payments from Medicare and Medicaid, or Medicaid alone; they cannot bill you for the 15% more than the Medicare-approved amount (which they could do if you were not on Medicaid).

2. Fees to States for Medicaid Services

Federal law permits states to charge some small fees to people who qualify for Medicaid as Medically Needy. (See Section B, above, for definition.) If you qualify as Categorically Needy, however, states can charge you a fee only for optional covered services. (See Section C2, above, for a full description of optional services.) State Medicaid charges will take one of three forms: an enrollment fee, a monthly premium, or copayments.

a. Enrollment Fee

Some states charge a small, one-time-only fee when Medically Needy people first enroll in Medicaid. This fee cannot be charged to people who are considered Categorically Needy.

b. Monthly Premium

States are permitted to charge a small monthly fee to people who qualify for Medicaid as Medically Needy. The premium may be charged whether or not Medicaid services are actually used that month. The amounts vary with income and assets, but usually come to no more than a few dollars.

c. Copayments

State Medicaid programs are permitted to charge a copayment for each Medicaid-covered service you receive. A copayment can be charged to the Medically Needy for any service, and to the Categorically Needy for optional services only. (See Section C2, above, for description of optional services.)

Medicaid and Private Health Insurance

Insurance companies are not permitted to sell you a medigap insurance policy if you are on Medicaid. However, you are permitted to have other private health insurance—such as that provided by a retirement program or a policy you purchase to protect against a specific illness—and still qualify for Medicaid.

Medicaid will deduct the amount of your private health insurance premiums from the calculation of your income when determining whether you are under the allowable income levels to qualify.

However, if you do have private health insurance, and a medical service is covered by both your insurance and by Medicaid, Medicaid will pay only the amount your insurance doesn't. If you receive a payment directly from your insurance company after Medicaid has paid that bill, you must return that insurance money to Medicaid.

F. Other State Assistance

Many people with low income and assets have trouble paying the portion of medical bills left unpaid by Medicare, cannot afford private medigap insurance, but do not qualify for Medicaid. If this is your situation, you may still get help paying Medicare premiums and portions of Medicare-covered costs that Medicare does not pay.

Three cost-reduction programs—called Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualifying Individual (QI)—are administered by each state's Medicaid program. They do not offer the extensive coverage beyond Medicare that Medicaid does, but the savings to you in Medicare-related medical costs can be substantial.

I. Qualified Medicare Beneficiary (QMB)

If you are eligible for Medicare and meet the income and asset eligibility requirements for the QMB program, your state will pay all of your Medicare Part A and Part B premiums, deductibles, and coinsurance. Depending on how much you use Medicare-covered services in a year, this could mean a savings of up to several thousand dollars.

a. Income Limits

To be eligible as a QMB, your income must be no more than slightly above the national poverty level. This figure is established each year by the federal government; in 2004, the income level

was about \$13,000 per year or \$1,081 per month for an individual; \$19,000 per year or \$1,578 per month for a married couple. These figures are slightly higher in Alaska and Hawaii. These amounts will go up slightly as the cost-of-living figures are calculated in April of each year.

Certain amounts of income are not counted in determining QMB eligibility. Particularly if you are still working and most of your income comes from your earnings, you may be able to qualify as a QMB even if your total income is more than twice the poverty level. QMB follows the SSI income guidelines, described in Chapter 6, Section A3. If, after applying these rules, you are anywhere close to the QMB limits, it is worth applying for it.

b. Asset Limits

There is a limit on the value of the assets you can own and still qualify as a QMB—generally, no more than \$4,000 for an individual and \$6,000 for a married couple. However, many assets, such as your house, your car, and certain personal and household goods, are not part of the resources that are counted. (See Chapter 6, Section A3, for how SSI counts assets.)

2. Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual

If your income is slightly too high for you to qualify for QMB benefits, you may still be eligible for one of two other state medical assistance programs: Specified Low-Income Medicare Beneficiary (SLMB) or Qualifying Individual

(QI). The resource limits for eligibility are the same as for a QMB, but the income limits are 20%–80% higher, depending on the program.

If your counted monthly income—after the same adjustments made in calculating income for SSI purposes (see Chapter 6, Sections A1 and A2, for these calculations)—is under \$2,000 for an individual, or \$2,500 for a couple, you are likely to qualify for SLMB or QI support. (These figures go up slightly each year.)

Because the SLMB and QI programs are for people with higher incomes, they have fewer benefits than the QMB program. The SLMB and QI programs pay all or part of the Medicare Part B monthly premium, but do not pay any Medicare deductibles or coinsurance amounts. Nonetheless, this means potential savings of more than \$500 per year.

G. Applying for Medicaid, QMB, SLMB, or QI

Before you can get coverage by the Medicaid, QMB, SLMB, or QI programs, you must file a written application separate from your Medicare application. An application for Medicaid also serves as an application for QMB, SLMB, or QI. If you are found ineligible for one program, you may still be found eligible for one of the others.

This section explains some of the things you will need to do and documents you will need to gather to file a Medicaid, QMB, SLMB, or QI application.

I. Where to File

To qualify for Medicaid or the QMB, SLMB, or QI programs, you must file a written application with the agency that handles Medicaid in your state—usually your county's Department of Social Services or Social Welfare Department.

In many states, if you are applying for SSI benefits at your local Social Security office, that application will also serve as a Medicaid application. You will be notified of Medicaid eligibility at the same time as you receive notice regarding SSI. (See Chapter 6 for a full discussion of the SSI program.)

If you or your spouse is hospitalized when you apply for Medicaid, ask to see a medical social worker in the hospital. He or she will help you fill out the application.

2. Required Documents and Other Information

Since eligibility for Medicaid and the QMB, SLMB, or QI programs depends on your financial situation, many of the documents you must bring to the Medicaid office are those which will verify your income and assets.

Although a Medicaid eligibility worker might require additional specific information from you, you will at least be able to get the application process started if you bring:

- pay stubs, income tax returns, Social Security benefits information, and other evidence of your current income

- papers showing all your savings and other financial assets, such as bankbooks, insurance policies, and stock certificates
- automobile registration papers if you own a car
- your Social Security card or number
- information about your spouse's income and separate assets, if the two of you live together, and
- medical bills from the previous three months, as well as medical records or reports to confirm any medical condition that will require treatment in the near future. If you don't have copies of these bills, records, or reports, bring the names and addresses of the doctors, hospitals, or other medical providers who are treating you.

Even if you don't have all these papers, go to your local social services or social welfare department office and file your application for Medicaid as soon as you think you may qualify. The Medicaid eligibility workers will tell you what other documents you need—and sometimes can explain how to get necessary papers you don't have, or help get them for you.

3. Application Procedure

A Medicaid eligibility worker—or an SSI eligibility worker if you apply for SSI at a local Social Security office—will interview you and assist you in filling out your application. There may be lots of forms to fill out, and you may have to return to the office for several different interviews.



Do not get discouraged. Delays, repeated forms, and interviews do not mean you will not be approved. The state has created procedures that make it difficult for people to get through the qualification process, driving some people to give up on benefits to which they are entitled. Patience is not only a virtue, it is an absolute necessity.

Normally, you will receive a decision on your Medicaid application within a couple of weeks after you complete the forms and provide the necessary information. The law requires that a decision be made within 45 days. If you don't hear from Medicaid within a month of your application, call the eligibility worker who interviewed you. Sometimes it takes a little polite pushing to get a decision out of an overworked social services agency.

4. Retroactive Benefits

If you are found to be eligible and have already incurred medical bills, Medicaid may cover some of them. This retroactive eligibility can go back to the beginning of the third month before the date you filed your application. Make sure to show your Medicaid eligibility worker any medical bills you have from this period.

If you are denied eligibility for Medicaid, QMB, SLMB, or QI, you have a right to appeal. (See Section H, below, for appeal procedures.)

5. Review of Eligibility

How long your Medicaid coverage will last depends on your finances and your medical costs. Medicaid eligibility is reviewed periodically, usually every six months and at least once a year.

If, upon review, they find that your financial situation has changed to put you over the eligibility limits for your state's Medicaid program, your coverage may be discontinued. Until then, you will be continued on Medicaid or QMB, SLMB, or QI coverage, even if your income or assets put you over the limits some months before.

Likewise, if you became eligible for Medicaid as Medically Needy because of high medical costs, but those medical costs have ended, you may be dropped from Medicaid when your review is completed. Until the review, however, you will remain on Medicaid regardless.

If new medical costs arise after your coverage has been ended, you may apply again for Medicaid coverage.

H. What to Do If You Are Denied Coverage

If you are denied Medicaid, QMB, SLMB, or QI coverage for which you believe you are eligible, go immediately to the office where you applied. Ask about the procedure in your state for getting a hearing to appeal that decision. In some states, if you request a hearing in writing within ten days after receiving the notice saying that your coverage is going to end, your coverage can stay in effect until after the hearing officer makes a decision.

At an appeal hearing, you will be able to present any documents or other papers—proof of income, assets, medical bills—that you think

support your claim. You will also be allowed to explain why the Medicaid decision was wrong. If expected medical bills, which you claim will qualify you as Medically Needy, are the main question concerning your eligibility, then a letter from your doctor explaining your condition and the expected cost of treatment would be important.

The hearing itself is usually held at or near the welfare or social service office. You are permitted to have a friend, relative, social worker, lawyer, or other representative appear with you to help at the hearing.

Although the exact procedure for obtaining this hearing, and the hearing itself, may be slightly different from state to state, they all resemble very closely the hearings given to applicants for Social Security benefits. (See Chapter 8 for a full discussion of Social Security hearings.)

You should be notified of the decision on your appeal within 90 days after the hearing.

Getting Assistance With Your Appeal

If you are denied Medicaid, QMB, SLMB, or QI, you may want to consult with someone experienced in the subject to help you prepare your appeal. The best place to find quality free assistance with these matters is the nearest office of the State Health Insurance Assistance Program (SHIP). (See Chapter 12, Section G, for contact information.)

If there is no SHIP office near you, you may be able to find other assistance through your local senior center or by calling the Senior Information line listed in the white pages of your telephone directory.

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